

PLACE PT LABEL HERE

MALE MEDICAL HISTORY / REVIEW OF SYSTEMS

Date: ____ / ____ / ____ Age: _____

PERSONAL HISTORY		
1. Are you being treated for any illness/condition now?	YES	NO
If yes, what?		
2. Do you smoke cigarettes?	YES	NO
If yes, how many per day?		
3. Do you drink alcohol?	YES	NO
If yes, how often?		
4. Do you use street drugs?	YES	NO
If yes, what?		
5. Do you use over-the-counter drugs?	YES	NO
If yes, what?		
6. Do you take prescription drugs?	YES	NO
If yes, what?		
7. Do you feel safe in your current relationship?	YES	NO
8. Do you have concerns about domestic violence?	YES	NO
9. Is anyone forcing you to have sex?	YES	NO
STAFF COMMENTS:		
SEXUAL HISTORY		
1. Are you currently sexually active?	YES	NO
2. When was the last time you had sex?		
3. How many sexual partners do you currently have?		
4. How long have you been with your current partner(s):		
5. How many partners have you had in the past 12 months?		
6. Do you have sex with: () men () women () both		
7. Do you participate in (check ✓ all that apply):		
() oral sex () vaginal sex () anal sex () outer course		
8. At what age did you first start having sex?		
9. Do you have sexual concerns?	YES	NO
STAFF COMMENTS:		
HEMATOLOGICAL / LYMPHATIC		
1. Do you have liver disease, hepatitis or gall bladder disease?	YES	NO
2. Do you have a blood clotting disorder?	YES	NO
3. Do you have a history of cancer?	YES	NO
STAFF COMMENTS:		
RESPIRATORY		
1. Do you have lung disease (asthma, TB)?	YES	NO
STAFF COMMENTS:		

CARDIOVASCULAR – Do you have or have you ever had:		
1. Varicose veins/phlebitis?	YES	NO
2. High blood pressure?	YES	NO
3. High cholesterol or fats?	YES	NO
4. Heart disease, heart surgery, or heart murmur?	YES	NO
5. Stroke or stroke-like symptoms?	YES	NO
STAFF COMMENTS:		
GASTROINTESTINAL – Do you have or have you ever had:		
1. Stomach problems, bowel problems, or ulcers?	YES	NO
STAFF COMMENTS:		
MUSCULOSKELETAL		
1. Do you ever have swollen/painful joints?	YES	NO
2. How many times have you broken a bone?		
3. Do you have any sensory difficulties?	YES	NO
STAFF COMMENTS:		
NEUROLOGICAL – Do you have or have you ever had:		
1. Migraines/severe headaches diagnosed by a Dr.?	YES	NO
2. Visual changes not related glasses or contacts?	YES	NO
3. Fainting when your blood is drawn?	YES	NO
4. Seizure disorder/epilepsy?	YES	NO
STAFF COMMENTS:		
ENDOCRINE		
1. Do you have night sweats/ hot flashes?	YES	NO
2. Do you have diabetes/	YES	NO
3. Do you have thyroid disease?	YES	NO
STAFF COMMENTS:		
ALLERGY / IMMUNOLOGY		
1. Do you have any allergies?	YES	NO
2. Are you up to date with your rubella vaccination?	YES	NO
STAFF COMMENTS:		

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FAMILY HISTORY				
Family history not available <input type="checkbox"/>				
Has your biological family (mother, father, brother, sister) had any of the following (circle all that apply):				
Diabetes	MOTHER	FATHER	BROTHER	SISTER
High blood pressure	MOTHER	FATHER	BROTHER	SISTER
Stroke before age 55	MOTHER	FATHER	BROTHER	SISTER
Heart disease before 55	MOTHER	FATHER	BROTHER	SISTER
High cholesterol or fats	MOTHER	FATHER	BROTHER	SISTER
<i>STAFF COMMENTS:</i>				
BIRTH CONTROL				
1. Are you currently using a birth control method?			YES	NO
If yes, what?				
2. What birth control method does your partner(s) use?				
<i>STAFF COMMENTS:</i>				

GENITOURINARY – Do you have or have you ever had:		
1. Urinary tract, bladder, kidney infections or diseases?	YES	NO
2. Pain or bleeding with sex?	YES	NO
3. Any of the following (check ✓ all that apply):		
() chlamydia	() gonorrhea	() genital warts
() herpes	() syphilis	() HIV
4. Severe scrotal injury?	YES	NO
5. Fluid pocket inside scrotum (hydrocele)?	YES	NO
6. Hernia?	YES	NO
7. Undescended testicle?	YES	NO
8. Infection of the reproductive tract, testes, epididymis, vas deferens or prostate?	YES	NO
<i>STAFF COMMENTS:</i>		
PSYCHOLOGICAL		
1. Do you have depression, mental illness, or anxiety disorder?	YES	NO
<i>STAFF COMMENTS:</i>		

I give the above information freely. It is complete and correct to the best of my knowledge. I understand that it is for Planned Parenthood® use only and will not be released to anyone else without my written permission unless ordered to do so by court order.

Patient Signature: _____

Date: _____

Medical Provider Signature: _____

Date: _____

Planned Parenthood Arizona
5651 N. 7th Street
Phoenix, Arizona 85014
1.800.230.PLAN (7526)

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood® may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood Arizona's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in Notice of Health Information Privacy Practices.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood Arizona's notice of health information privacy practices.

Signature of patient _____ Date

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____ Date

CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____ Date
Relationship to patient _____

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness _____ Date

PATIENT INFORMATION FORM

PLACE PT LABEL HERE

Last Name		First Name		Middle Initial	Nickname	
Social Security Number (XXX-XX-XXXX) - -		Birth Date (MM/DD/YYYY) / /		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		
Street Address				How do you prefer we contact you? <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone		
City		State	ZIP Code	County		
Race (check all that apply) <input type="checkbox"/> American Indian Or Alaska Native <input type="checkbox"/> Asian Or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Other <input type="checkbox"/> White		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Significant Other <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Student Status <input type="checkbox"/> Full Time Student <input type="checkbox"/> Not a Student <input type="checkbox"/> Part Time Student	
Home Phone ()	Day Phone ()		Alternate Phone ()		E-mail	
Emergency Contact Name		Emergency Contact Phone # ()		How did you hear about Planned Parenthood® Arizona?		
Family Income \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			Family Size (the number of people supported by your income)			
Under Title X of the Public Health Services Act funds are available for some services at no cost or discounted based on your family income and household size. Do you want to be considered for this program? <input type="checkbox"/> YES <input type="checkbox"/> NO						
Full Family Planning Title X Service available at: Archer, Maryvale, Mesa, Yuma						
Minors: Reporting of sexual abuse or coercion to the appropriate authorities may be required.						
Confidentiality will be maintained except as mandated by state law.						
INSURANCE / AHCCCS INFORMATION						
Policyholder Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Significant Other <input type="checkbox"/> Spouse						
Policyholder Last Name		Policyholder First Name		Policyholder Social Security # - -	Policyholder Birth Date / /	
Policyholder Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Policyholder Address, City, State & ZIP <input type="checkbox"/> Same as patient			Policyholder's Phone Number ()	
Plan Name		Policy Number		Group Number		
Plan Address, City, State & ZIP				Contact Phone # ()		

I acknowledge that all of the above information is true and correct and that it has been furnished to this office with full knowledge. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES.** If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Signature of Patient

Date

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INSURANCE & TITLE X VERIFICATION

*Insurance/AHCCCS eligibility and verification of benefits must be performed for each patient encounter.
Title X eligibility must be performed every six months, along with a PIF update.*

Verification Date	Date of Service	Procedure or Service:	Is this a covered benefit under the members plan?
/ /	/ /	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance effective on DOS?	Co-Pay Amount:	Co-Insurance Amount:	Has Deductible been met?
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the procedure or service need prior authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No			Prior authorization #: _____
If PPAZ is not in the member's network, does the patient have out-of network benefits?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments: _____ _____			

Name of Insurance Representative spoken with to verify insurance: _____

Signature of Staff Verifying Insurance Information _____

TITLE X VERIFICATION / ELIGIBILITY

Title X Excluded Visit: Yes No ***IF "NO" complete the following:***

Title X Program Eligible: Yes No

Income Level: _____ Slide % _____

If Client income is less than 100% of FPL, client was encouraged to follow up with AHCCS / DES Yes No

Staff Signature: _____ **Date:** _____

ABORTION QUALIFIER CHECKLIST FOR MINORS

Pursuant to ARS - 36 - 2152 the following item qualifies this patient for an abortion.

- Parental Consent does not apply
- Parental Consent - signed PPAZ Parental Consent form on file
- Court Order - copy of Court Order on file
- Sexual Abuse - signed Sexual Abuse Certification on file (Physician must report and forward sample fetal tissue)
- Physicians Certification - copy of certification from physician that states a medical condition as described in ARS - 36 - 2152 (g2)
- Emancipated - copy of marriage license or military documents on file

Type of ID Shown: _____ **ID #:** _____

Staff Signature: _____ **Date:** _____