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FEMALE 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:		

PREGNANCY HISTORY	
1. How many times have you been pregnant?	
2. Number of live births:	3. Number of living children:
4. Age of each child:	5. Number of premature:
6. Number of c-sections:	7. Number with birth defects:
8. Number of fetal death:	9. Number of abortions:
10. Number of miscarriages:	11. Number of ectopic:
12. Number of vaginal deliveries:	
13. Are you breast-feeding now?	YES NO
14. Do you have plans for pregnancy in the next year?	YES NO
STAFF COMMENTS:	

MENSTRUAL HISTORY		
1. What was the first day of last menstrual period? Date: / /		
2. Was this a normal period?	YES	NO
3. Are your periods usually regular?	YES	NO
4. How many days does your bleeding usually last?		
5. How many days are your cycles?		
6. Is your period usually: ( ) light ( ) medium ( ) heavy		
7. At what age did your period begin?		
8. Do you have the following with your periods (check ✓ all that apply):		
( ) cramps ( ) nausea ( ) headaches ( ) back aches		
( ) pre-menstrual tension ( ) bleeding/spotting in between periods		
STAFF COMMENTS:		

CARDIOVASCULAR – *Do you have or have you ever had:*		
1. Swollen feet/legs?	YES	NO
2. Varicose veins/phlebitis?	YES	NO
3. High blood pressure?	YES	NO
4. High cholesterol or fats?	YES	NO
5. Heart disease, heart surgery, or heart murmur?	YES	NO
6. Stroke or stroke-like symptoms?	YES	NO
STAFF COMMENTS:		

GASTROINTESTINAL – *Do you have or have you ever had:*		
1. Frequent nausea/vomiting?	YES	NO
2. Diarrhea on a regular basis?	YES	NO
3. Blood in your stool?	YES	NO
4. Stomach problems, bowel problems, or ulcers?	YES	NO
5. Severe heartburn?	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. Are you frequently thirsty for no reason?	YES	NO
2. Do you have swelling in your neck?	YES	NO
3. Do you have night sweats/ hot flashes?	YES	NO
4. Do you have diabetes/gestational diabetes?	YES	NO
5. 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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FEMALE MEDICAL HISTORY / REVIEW OF SYSTEMS

SEXUAL HISTORY

1. Are you currently sexually active? **YES** **NO**
2. When was the last time you had sex?
3. Could you be pregnant now? **YES** **NO**
4. How many sexual partners do you currently have?
5. How long have you been with your current partner(s):
6. How many partners have you had in the past 12 months?
7. Do you have sex with: ( ) men ( ) women ( ) both
8. Do you participate in (check ✓ all that apply):
   ( ) oral sex ( ) vaginal sex ( ) anal sex ( ) outer course
9. At what age did you first start having sex?
10. Do you have sexual concerns? **YES** **NO**

STAFF COMMENTS:

FAMILY HISTORY

Family history not available ☐

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**
Breast cancer	**MOTHER**	**FATHER**	**BROTHER**	**SISTER**
Ovarian cancer	**MOTHER**	**SISTER**		

STAFF COMMENTS:

BIRTH CONTROL

1. Are you currently using a birth control method? **YES** **NO**
   If yes, what?
2. What birth control method do you desire?
3. If you have ever used birth control in the past, please list:

Type of birth control	When used	Problems, if any

STAFF COMMENTS:

GENITOURINARY

1. Have you had urinary tract, bladder, kidney infections or diseases? **YES** **NO**
2. Do you have pain or bleeding with sex? **YES** **NO**
3. When was your last Pap smear? Date: / /
4. Have you ever had an abnormal Pap smear? **YES** **NO**
   If yes, when?
5. Have you had any of the following (check ✓ all that apply):
   ( ) colposcopy ( ) cryosurgery ( ) laser ( ) LEEP
   ( ) endometriosis ( ) fibroids ( ) ovarian cysts
6. Have you had any of the following (check ✓ all that apply):
   ( ) chlamydia ( ) gonorrhea ( ) genital warts
   ( ) herpes ( ) syphilis ( ) PID ( ) HIV
7. Did your mother take DES when she was pregnant with you? **YES** **NO**

STAFF COMMENTS:

HEMATOLOGICAL / LYMPHATIC

1. Have you ever had a breast lump or discharge from your nipples? **YES** **NO**
2. Do you have swollen glands under your arms? **YES** **NO**
3. If you get cut, do you bleed excessively? **YES** **NO**
4. Do you have frequent bruising for no reason? **YES** **NO**
5. Have you ever been anemic? **YES** **NO**
6. Do you have a blood clotting disorder? **YES** **NO**
7. Have you ever had breast surgery? **YES** **NO**
8. Do you have a history of cancer? **YES** **NO**

STAFF COMMENTS:

RESPIRATORY

1. Do you have lung disease (asthma, TB)? **YES** **NO**

STAFF COMMENTS:

PSYCHOLOGICAL

1. Do you have depression, mental illness, or anxiety disorder? **YES** **NO**

STAFF COMMENTS:

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: ____________

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Client Information

HIV TEST

You have asked for an HIV antibody test. HIV, the human immunodeficiency virus, can cause AIDS — Acquired Immune Deficiency Syndrome. It is important for you to read and understand the following information before you are tested or counseled. If you would like more information about HIV/AIDS, please ask us. We can also help you if you need referral to other health care providers.

You must be tested for the HIV antibody to tell if you have HIV. Bodies respond to infection by making antibodies. It can take three months after infection for a body to make enough HIV antibodies to be detected. For a few people, it may take as long as six months. There are several ways to test for HIV antibodies. It can be done with samples of blood, urine, or saliva. There may be slight differences in the accuracy of tests. Talk to us about which test may be best for you.

If the results of the test are "positive," it means that antibodies to HIV have been found in your body. All positive results are confirmed with another test before the results are given to you. If the results are "negative," it means that no antibodies to HIV have been detected.

All counseling, testing, and referrals services are confidential. Confidential means Planned Parenthood ® will know your name. Some states require that HIV test results be kept separate from the client's medical records. This means that HIV test results would not be included if the medical records were sent to another health care provider. Other states allow the results to be included in the medical record.

Anonymous testing means that a code instead of the clients name is used to record the test results. Some states do not permit anonymous testing. If you want an anonymous test, please tell us before filling out any papers.

ADVANTAGES OF TAKING AN HIV TEST

Knowing whether or not you are infected can be helpful:

- People who know they have HIV can start medical treatment to slow the development of disease.
- People who know they have HIV can change behaviors that may infect others.
- People who have taken chances about getting HIV and find out that they don't have it may be motivated to lower their risks.
- People who've lowered their risks for HIV and find that they are still uninfected may be motivated to stay low-risk.
- People who know whether or not they're infected may be more careful about protecting themselves and others.

We will be happy to talk with you if you need more information about high-risk and low-risk behaviors.

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Getting samples for tests is easy:

- Samples of urine or saliva can be taken with no pain or discomfort.
- Drawing blood from a finger or vein may cause slight pain and discomfort as the needle punctures the skin. A small bruise may also develop where the puncture takes place.

DISADVATAGES OF TAKING AN HIV TEST

No HIV antibody test is 100 percent accurate.
There is a risk that the results may be inaccurate or inconclusive. The test may have been done too soon to detect antibodies. In rare cases, the test itself may be flawed. Inconclusive or inaccurate results can be very upsetting and frustrating. We are here to talk with you in this case.

Knowing that they have HIV can have significant impact on people and the people they are close to. That's why many states and cities have laws that prevent clinicians and employers from telling other people that a client or employee has HIV/AIDS.

People who have or are thought to have HIV may be discriminated against.
It against federal law to discriminate against people with HIV/AIDS, or other disabilities, about jobs, housing, medical care, and in most places that are open to the public. Many states and cities have other specific protections for people who have or who are thought to have HIV/AIDS. But discrimination may yet occur in these or other circumstances.

Although medical treatment may slow the development of disease, there is no cure for HIV/AIDS.

ALTERNATIVES

There is a variety of HIV antibody screening tests. If we are unable to provide you with a specific test, we can refer you to other providers.

You may choose not to be tested but to get personalized counseling on reducing your risk of getting or transmitting HIV.

SPECIAL INSTRUCTIONS
Your health is important to us. You may be asked to return to the clinic to get your test results, have counseling, or obtain referral services. It is very important to keep this appointment. Please contact us if you cannot make the appointment or are seeing another health care provider.

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HOW TO AVOID GETTING OR TRANSMITTING HIV

The Human Immunodeficiency Virus (HIV), which can cause AIDS, is not spread by contact such as touching, hugging, sneezing, coughing or kissing.

HIV is spread in blood, semen, breast milk, and vaginal secretions. The only way to be absolutely safe from getting HIV is by not having sexual intercourse (vaginal, anal or oral) and by not sharing needles and equipment to shoot drugs.

If you have any of the risk factors listed below, or if you aren't sure, you may want to have an HIV test or screening to find out if you have been infected. The following behaviors increase your risk of HIV infection:

- More than one sex partner (casual or steady);
- Sexual activities without protection (no condom, vaginal pouch, or dental dam) including vaginal, anal, and oral sex, both receptive and insertive activities;
- Sex with a person known to be HIV-positive;
- Sharing needles or having sex with persons who share needles;
- History of STI's and having sex with persons who have STI's especially genital lesions;
- Sex in exchange for drugs, money, or other inducements;
- Use of substances such as alcohol, cocaine, etc., in connection with sexual activity;
- Inconsistent condom use;
- Exposure to the following since 1978:
  1. Artificial insemination with untested donor semen;
  2. Blood or blood products transfusion (especially between 1978 and March of 1985);
  3. Tissue or organ transplantation (especially between 1978 and March of 1985);
  4. Unsterile tattoo, body piercing, scarification or other body decorating that may draw blood.

Women considering becoming pregnant, or planning to continue a pregnancy, may also wish to have an antibody-screening test. Anyone may get an antibody-screening test simply by requesting it.

If your test is negative, or if you decide not to take the test, your best protection is to not share needles, and to abstain from sex, or follow the "safer sex" suggestions.

"Safer Sex" Suggestions
Massage, hugging, body to body rubbing, friendly kissing (dry), touching your own genitals (masturbation), hand-to-genital touching (hand job), and mutual masturbation are safe activities that do not involve exchange of body fluids. The following is a summary of what the experts think.

RISK CATEGORIES	
VERY LOW RISK (No reported cases of HIV due to these behaviors):	
• Masturbation - Mutual Masturbation • Touching - Massage • Erotic Massage - Body Rubbing • Kissing - Deep Kissing • Oral Sex on a Man with a Condom	• Oral Sex on a Woman with a Dental Dam, Plastic Wrap, or Cut-Open Condom • Avoid getting semen or blood into the mouth or on broken skin. Don't worry about getting vaginal secretions, menstrual flow, urine, or semen on unbroken skin away from the mouth or vulva.
LOW RISK (Rare reported cases of HIV due to these behaviors): • Oral Sex • Vaginal Intercourse with a Condom or a Vaginal Pouch • Anal Intercourse with a Condom Avoid getting semen or blood on broken skin or into the mouth, vagina or anus.	HIGH RISK (Millions of reported cases of HIV due to these behaviors): • Vaginal Intercourse Without a Condom • Anal Intercourse Without a Condom

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RISK FACTORS (continued)	
Some of the Drugs That Encourage Taking Risks with Sex: • Alcohol • Speed • Poppers • Marijuana • Cocaine • Crack • Ecstasy	Some of the Feelings That Encourage Taking Risks with Sex: • Desire to be Swept Away • Anger • Shame • Fear of Losing a Partner • Insecurity • Low Self-Esteem • Embarrassment • Need To Be Loved

Limit the number of different sexual partners in your life. The more sexual partners you have, the greater the risk you run of getting HIV and other sexually transmitted infections (STIs).

Latex condoms, other barriers, and spermicides are not 100% safe, because they may fail and because people make mistakes. Only you can decide how much risk you want to take.

Remember that practicing some forms of very low-risk sex (skin to skin contact but no transmission of blood, semen, or vaginal fluids) does not eliminate your risk of acquiring other sexually transmitted diseases such as herpes, warts, pubic lice, and scabies.

If You take Intravenous Drugs
Do not use or share needles and equipment to take street drugs.

HOW TO STERILIZE YOUR WORKS (NEEDLES AND SYRINGES)

1. Pour some bleach in a cup and some water into another cup.
2. Pull bleach into the barrel of the syringe until it fills all the way up to the plunger, shake it a bit, and leave it in for a minute. Squirt it out into a sink or the toilet.
3. Pull water into the barrel of the syringe until it fills all the way up to the plunger and shake it a bit. Squirt it out into a sink or the toilet.
4. Repeat bleach, water, bleach, water for a total of 3 times with each. Rinse out with water one last time to be sure.
5. Wipe out the cooker or spoon with a bleach-soaked piece of cotton and then rinse with running water. Dry it off.
6. Do not share syringe or cooker without first cleaning them. Do not share cottons.

For more information, ask your clinician.

If both partners in a couple are HIV negative (if they both have had two negative antibody tests 6 months apart) and both do not have sex with others or share needles and equipment to shoot drugs, they may have unprotected sex with each other with very little risk of transmitting the AIDS virus.

If you have had sexual relations or shared needles or equipment with someone you think could have HIV, or if you aren't sure, you may want to have an HIV test to find out if you have been infected.

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HIV RISK & TESTING NEEDS ASSESSMENT

Have you been tested for HIV/AIDS before?

- ☐ Yes   Approximate date of last test: ____________________________
- ☐ No

What parts of your body have you used to have sex? (Check all that apply):

- ☐ Vagina
- ☐ Penis
- ☐ Anus
- ☐ Mouth
- ☐ Other: ____________________________________

What parts of the body has your partner(s) used? (Check all that apply):

Male Partners
- ☐ Penis
- ☐ Anus
- ☐ Mouth
- ☐ Other: ____

Female Partners
- ☐ Vagina
- ☐ Anus
- ☐ Mouth
- ☐ Other: ______________________________

Check any statements that are true for YOU (Check all that apply):

- ☐ Had sex without a condom
- ☐ Paid/been paid for sex
- ☐ Had sex while under the influence of alcohol/drugs
- ☐ Had sex with someone who has HIV/AIDS
- ☐ Injected drugs/shared needles
- ☐ Tested positive for a sexually transmitted infection
- ☐ Spent time in prison
- ☐ Other risks:___________________________

Check any statements that are true for YOUR PARTNER(S) (Check all that apply):

- ☐ Had sex without a condom
- ☐ Paid/been paid for sex
- ☐ Had sex while under the influence of alcohol/drugs
- ☐ Had sex with someone who has HIV/AIDS
- ☐ Injected drugs/shared needles
- ☐ Tested positive for a sexually transmitted infection
- ☐ Spent time in prison
- ☐ Other risks: __________________________

When was the last time you had sex? ___________________ **Did you use condoms/dental dams?** ☐ Yes ☐ No

How often do you and your partner(s) participate in the following? (Circle one):

Abstain from intercourse	**Always**	**Sometimes**	**Never**
Commit to a faithful relationship with only one person	**Always**	**Sometimes**	**Never**
Use condoms with every sex act	**Always**	**Sometimes**	**Never**
Share needles	**Always**	**Sometimes**	**Never**

- CONTINUED ON THE BACK -

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HIV CONSENT & TEST RESULT

Please initial here if you would like a copy of this test result ___________

Informed Consent:
I have read and understand the patient information sheets **About AIDS and the HIV Antibody Test or Screening** *and* **How to Avoid Getting or Transmitting HIV**. *I understand the difference between confidential and anonymous testing and that the testing I receive today is confidential. I have been advised what the HIV test or screening results mean and of the benefits and concerns of being tested or screened. I voluntarily consent to the withdrawal of blood and other bodily fluids from me as stated in the information sheets. Additionally, I understand a positive result may require additional confirmatory testing. I further understand that if my test result is positive, the information will be reported to the* AZ Department of Health *as required by law (Statute 36-604 & State Reg. R9-6-114). I understand that I do not have to be tested for HIV.*

Patient Signature ____ Date ______________________

STAFF USE ONLY

Client Received:

- ☐ Counseling only, testing declined
- ☐ Counseling and testing
- ☐ Client Information: HIV TEST
- ☐ HOW TO AVOID GETTING OR TRANSMITTING HIV
- ☐ *UniGold HIV Test: Subject Information* leaflet

☐ **UniGold Test**

Date: ___________ Test Lot #: ____________ Test performed by: ______________________ Result: ____________

Results given by: ________________________ (If Positive, Confirmatory Sample must be Obtained)

☐ **Blood Serum Test** ☐ **Check if Confirmatory Test**

Date: ___________

Collected by: ____

____

____

Result: _____________ Result Given by: _________________________

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HIV TESTING AND EDUCATION CHECKLIST

PRE-TEST EDUCATION Information to be discussed with all clients:

- ☐ Ask client if they have ever been tested for HIV. _______ No _______ Yes How long ago? _______
- ☐ Distinguish between HIV and AIDS testing. We are providing HIV antibody testing.
- ☐ Explain the difference between the tests offered at PPAZ: blood serum test, rapid UniGold testing, and OraSure.
- ☐ Explain difference between confidential and anonymous testing. Be sure client understands which he/she has chosen. We offer confidential only.
- ☐ Review window period. Antibodies take from 28 days to six months to develop. 90% of the population will seroconvert within 28 days. If testing is less than 6 months from exposure, enc. client to re-test.
- ☐ Discuss how HIV is transmitted (blood, semen, vaginal secretions & breast milk). These fluids can be transmitted sexually or though the sharing of needles. Remember to stress that needle sharing can mean IV drug use, body piercing, illegal steroid use and tattooing.
- ☐ Review client's "HIV Risk & Testing Needs Assessment" paperwork. Discuss risk reduction and safer sexual activity, reconciling any past high risk behaviors. Use the "ABC" model.
- ☐ **If client chooses blood serum or OraSure**, inform client of waiting period for test results. If client seems agitated or apprehensive assure client of ability to contact health center for support or concerns. Advise client to call on agreed date to confirm results have arrived and to then schedule an appointment for post-test counseling and results.
- ☐ **If client chooses UniGold**, explain that if the screening is positive, client must have a confirmatory blood serum to confirm positive results.
- ☐ Notify client positive results must be reported to ADHS as required by state law.
- ☐ Discuss the following and initial those items covered, as applicable:

_______ Parental involvement encouraged
_______ Coercion/Domestic Violence addressed
_______ Rubella/DES discussed
_______ Importance of folic acid addressed
_______ Exam, pap, other STD testing & BCM encouraged/offered

- ☐ Ask client if they have any questions or concerns not covered so far in the interview.

Staff Signature: ________________________ Date: ______________

POST-TEST EDUCATION Information to be discussed if negative result:

- ☐ Discuss risk reduction planning and goals. Document plan: ________________________
____
- ☐ If needed, review window period again and encourage client to return for re-test if needed or if high-risk behaviors cannot be reconciled.
- ☐ Condoms given.

COMMENTS: ____

Staff Signature: ________________________ Date: ______________

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POST-TEST EDUCATION: **Information to be discussed if positive result:**

☐ Two Elisa and one Western Blot tests have been run: "Your result is positive, you have been exposed to HIV". **(LONG PAUSE FOR THE INFORMATION TO SINK IN...)**

☐ Possible follow up questions: "How do you feel? Did you expect this result?"

☐ HIV disease is currently a manageable condition with proper medical evaluation. To help with your decision to start the current regimen of anti viral medications available you should first have your immune system evaluated with two tests. The first will be an immunocompetency profile (T-cell count), and the second a viral load test. This is not a death sentence by any means. As a result of the current medications available many people are living healthy and productive lives.

☐ Is there a current partner you should be notifying?

☐ County Health Department will be informed of this result and can help you with partner notification if you'd like.

☐ What were you planning to do the rest of the day? Who can you be with? Are you feeling at all unsafe? Do you need to speak with a counselor? Do you have the number of any hotlines/counselors/AIDS agencies?

☐ Counseling referral given

☐ Is there anything else you need from me today?

COMMENTS: ____

____

____

____

Staff Signature: ______________________ Date: ______________________

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Planned Parenhood 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).

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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

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PATIENT INFORMATION FORM

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Last Name	First Name	Middle Initial	Nickname
Social Security Number (XXX-XX-XXXX) – –	**Birth Date** (MM/DD/YYYY) / /	**Sex** ☐ Female ☐ Male	
Street Address		**How do you prefer we contact you?** ☐ E-mail ☐ Mail ☐ Phone	

City	State	ZIP Code	County

Race *(check all that apply)*	**Ethnicity**	**Marital Status**	**Student Status**
☐ American Indian Or Alaska Native ☐ Asian Or Pacific Islander ☐ Black ☐ Multiracial ☐ Other ☐ White	☐ Hispanic ☐ Non Hispanic	☐ Divorced ☐ Legally Separated ☐ Significant Other ☐ Married ☐ Single ☐ Widowed	☐ Full Time Student ☐ Not a Student ☐ 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 $____________________
☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ 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? ☐ YES ☐ NO

Full Family Planning Title X Service available at: *Archer, Maryvale, Mesa, Yuma*

Minors: Reporting of sexual abuse or coersion to the appropriate authorities may be required.

Confidentiality will be maintained except as mandated by state law.

INSURANCE / AHCCCS INFORMATION

Policyholder Relationship to patient: ☐ Self ☐ Parent ☐ Significant Other ☐ Spouse

Policyholder Last Name	**Policyholder First Name**	**Policyholder Social Security #** – –	**Policyholder Birth Date** / /
Policyholder Sex ☐ Female ☐ Male	**Policyholder Address, City, State & ZIP** ☐ 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 refereed 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**

09-125.6-2.10

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PLACE PT LABEL HERE

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? ❑ Yes ❑ No

Insurance effective on DOS? ❑ Yes ❑ No | Co-Pay Amount: ______ | Co-Insurance Amount: ______ | Has Deductible been met? ❑ Yes ❑ No | Deductible amount: ______

Does the procedure or service need prior authorization? ❑ Yes ❑ No Prior authorization #: ______

If PPAZ is not in the member's network, does the patient have out-of network benefits? ❑ Yes ❑ No

Comments:

______

______

Name of Insurance Representative spoken with to verify insurance: ______

Signature of Staff Verifying Insurance Information ______

TITLE X VERIFICATION / ELIGIBILTY

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:** ______

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Chlamydia/Gonorrhea/HIV Screening Visit

Last Name	First Name	Client #	Date

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Symptoms of Gonorrhea and Chlamydia

There are usually no symptoms. But if they are present, they may feel like:

Women: unusual vaginal discharge, burning with urination, lower abdominal or low back pain, pain with sex, or bleeding after sex or between periods

Men: discharge from the penis, a burning sensation with urination, or burning and itching around the opening of the penis

Check below:

☐ Yes ☐ No Was your sex partner(s) recently treated for chlamydia or gonorrhea?
☐ Yes ☐ No Is you sex partner(s) having any of the symptoms listed above?
☐ Yes ☐ No Are you having any of the symptoms listed above?
☐ Yes ☐ No Are you allergic to any medicines? If yes, please list:____

____
Client's Signature Date

FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE

☐ Yes ☐ No Client reports symptoms. ☐ Appt. offered. ☐ Declined ☐ Scheduled today / ___________ (date)
☐ Campaign materials given. ☐ CI HIV given.
☐ Rapid HIV test done. Oral / Blood Results: ☐ Negative ☐ Positive ☐ Confirmatory test sent. ☐ Client informed.
☐ Urine GC/CT sent.
Notes:

____ ______________
Staff signature Date

Plan:

☐ Treat today. ☐ NKDA
☐ Azithromycin 1 gm orally in single dose
☐ Cefixime 400 mg orally in single dose
☐ Other ___________________________
☐ Medication CIs given. ☐ Package inserts given.
☐ Await results.
☐ Other ____
Notes:

☐ Provide partner treatment today. ☐ NKDA ☐ Unknown
☐ Azithromycin 1 gm orally in single dose
☐ Cefixime 400 mg orally in single dose
☐ Other ___________________________
☐ Partner treatment CIs given. ☐ Package inserts given.
☐ Refer partner for treatment. ☐ PP ☐ other

____
Clinician signature Date

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FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE

Results:
GC ☐ Negative ☐ Positive
CT ☐ Negative ☐ Positive
Confirmatory HIV ☐ Negative ☐ Positive ☐ Not done

Plan, if any positives:
☐ Treat. ☐ NKDA ☐ Treated at visit.
☐ Azithromycin 1 gm orally in single dose
☐ Cefixime 400 mg orally in single dose
☐ Other ___________________________
☐ Partner treatment.
☐ Azithromycin 1 gm orally in single dose
☐ Cefixime 400 mg orally in single dose
☐ Other ___________________________
☐ Refer partner for treatment. ☐ PP ☐ other
☐ Refer for HIV care.
Notes:

____
Clinician Signature Date

Notification attempts:

	Date	**Initial**	**Response**
1. TC – H W ER C			NA LM DC
2. Letter _________			
3. Letter _________			

Notes:

____
Staff Signature Date

Treatment:
Client picked up medication. Date:______
☐ For self. Lot #________ Lot #________
☐ Medication CIs given. ☐ Package inserts given.
☐ For partner. Lot #________ Lot #________
☐ Partner treatment CIs given. ☐ Package inserts given.
☐ Prescription called into pharmacy. Tel #____________

____
Staff Signature Date
Reminder : ☐ Not applicable
1. Letter _________ or
TC – H W ER C NA LM DC

TC – Telephone Call, H- Home, W- Work, ER- Emergency #, C- Cell, NA – no answer, LM – left message, DC- disconnected

01-17-3-09.10

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