

PLACE PT LABEL HERE

**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):

	MOTHER	FATHER	BROTHER	SISTER
Diabetes				
High blood pressure				
Stroke before age 55				
Heart disease before 55				
High cholesterol or fats				
Breast cancer				
Ovarian cancer				

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: \_\_\_\_\_

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

<input type="checkbox"/> 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

<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>	<b>Nickname</b>
<b>Social Security Number</b> (XXX-XX-XXXX) - -		<b>Birth Date</b> (MM/DD/YYYY) / /		<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Street Address</b>				<b>How do you prefer we contact you?</b> <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone	
<b>City</b>		<b>State</b>	<b>ZIP Code</b>	<b>County</b>	
<b>Race</b> (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		<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	<b>Marital Status</b> <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		<b>Student Status</b> <input type="checkbox"/> Full Time Student <input type="checkbox"/> Not a Student <input type="checkbox"/> Part Time Student
<b>Home Phone</b> ( )	<b>Day Phone</b> ( )		<b>Alternate Phone</b> ( )		<b>E-mail</b>
<b>Emergency Contact Name</b>		<b>Emergency Contact Phone #</b> ( )		<b>How did you hear about Planned Parenthood® Arizona?</b>	
<b>Family Income</b> \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			<b>Family Size</b> (the number of people supported by your income)		
<b>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?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b>Full Family Planning Title X Service available at:</b> Archer, Maryvale, Mesa, Yuma					
<b>Minors:</b> Reporting of sexual abuse or coercion to the appropriate authorities may be required.					
<b>Confidentiality will be maintained except as mandated by state law.</b>					
<b>INSURANCE / AHCCCS INFORMATION</b>					
<b>Policyholder Relationship to patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Significant Other <input type="checkbox"/> Spouse					
<b>Policyholder Last Name</b>		<b>Policyholder First Name</b>		<b>Policyholder Social Security #</b> - -	<b>Policyholder Birth Date</b> / /
<b>Policyholder Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male		<b>Policyholder Address, City, State &amp; ZIP</b> <input type="checkbox"/> Same as patient			<b>Policyholder's Phone Number</b> ( )
<b>Plan Name</b>		<b>Policy Number</b>		<b>Group Number</b>	
<b>Plan Address, City, State &amp; ZIP</b>				<b>Contact Phone #</b> ( )	

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

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?    Co-Pay Amount:    Co-Insurance Amount:    Has Deductible been met?    Deductible amount:

Yes     No    \_\_\_\_\_    \_\_\_\_\_     Yes     No    \_\_\_\_\_

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 / 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:** \_\_\_\_\_