

Welcome to Planned Parenthood!

Date: _____ Time: _____

Have you been to **THIS** clinic in the past two years? Yes No
Have you ever visited **any** Planned Parenthood Clinics before today's visit? Yes No

Name: _____			Age: _____		
<small>Last</small>	<small>First</small>	<small>Middle Initial</small>			
Date of Birth: _____		Social Security No. _____			
Please list any other name(s) you have used at Planned Parenthood: _____					
Please complete the address and phone number(s) where we MAY contact you:					
Address: _____			Apartment #: _____		
<small>STREET / PO BOX</small>					
<small>CITY</small>		<small>STATE</small>		<small>ZIP CODE</small>	
<small>COUNTY</small>					
Home Phone: _____		Work Phone: _____		Cell Phone: _____	
How do you prefer to be contacted? <input type="checkbox"/> any of the above, <input type="checkbox"/> mail, <input type="checkbox"/> phone (<input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell)					
REQUIRED: Who do we contact in case of an emergency or if you cannot be reached?					
Name: _____			Relationship: _____		
Address: _____					
Phone Number: (day) _____			(night) _____		

Please check (✓) ALL that apply to you:

Marital Status: Married Never Married Previously Married

Race: White Black/AA Am. Ind./Alaskan Asian Hawaiian/Pacific Isl. Other

Ethnic Origin: Hispanic

Sex: Male Female — What was the 1st day of your last menstrual period: _____

Have you had: your tubes tied an Essure procedure a hysterectomy a vasectomy

Have you: gone through menopause (with no period for at least 12 months)

Do you take hormone therapy (HT) and/or estrogen therapy (ET)? Yes No

Please check (✓) the reason(s) for your visit today:

<input type="checkbox"/> STD testing	<input type="checkbox"/> Birth control pills/patch/ring	<input type="checkbox"/> Birth control shot (Depo)
<input type="checkbox"/> Vaginal problems	<input type="checkbox"/> Well woman exam / annual exam	<input type="checkbox"/> Morning after pill (Emergency Contraception - EC)
<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Pap	<input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryotherapy <input type="checkbox"/> LEEP
<input type="checkbox"/> HIV testing	<input type="checkbox"/> Pregnancy testing	<input type="checkbox"/> Implanon Insertion <input type="checkbox"/> Implanon Removal
<input type="checkbox"/> IUD	<input type="checkbox"/> Gardasil (HPV Vaccine)	<input type="checkbox"/> Other: _____

Are you pregnant? Yes No Not sure

Do you have insurance? Yes No

Do you have Medicaid? Yes (*please present Card*) No

TX: Are you on WHP (Women's Health Program)?

Yes (*please present Card*) No

LA: Are you on Take Charge?

Yes (*please present Card*) No

I declare that the above information is true and correct:

CLIENT SIGNATURE _____

DATE _____

STAFF USE ONLY: ID verified YES NO