

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: _____	
Last	First	Middle Initial	
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>			
CITY _____		STATE _____	ZIP CODE _____
		COUNTY _____	
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

Are you on Take Charge? Yes (*please present card*) No

How did you hear about Planned Parenthood: Radio/TV/Newspaper Ad Telephone Yellow Pages Website
 PP speaker or program Word-of-mouth/friend Other medical provider or agency HIV Counselor Research

I would like to join Planned Parenthood's Action Network to receive updates on important reproductive healthcare issues by:

e-mail: _____ Phone Mail