Planned Parenthood®
of Southeast Iowa

Name ____________________ DOB __________ Age _____ Date __________ Pt. # ______

Review of Systems

Yes	No	General
		1. Is your health generally good?
		2. Are you being treated for any illness/condition now? If yes, what?
		3. Birth defects or genetic problems?
		4. Cancer? If yes, where/when?
		5. Eye problems? ☐ glasses ☐ disease ☐ other?
		6. Tobacco use? How old when you started? _______ How many cigarettes per day? _______ Smokeless tobacco cans/pouches per week? _______
		7. Alcohol use? How many drinks per week? _______
		8. Do you currently take medicine: prescription, over-the counter, or herbal? Please list:
		Cardio-Respiratory
		9. Mitral valve prolapsed?
		10. Heart murmur?
		11. Varicose veins?
		12. Blood clots (head/leg/lungs)?
		13. Stroke or stroke-like problems?
		14. High blood pressure?
		15. High cholesterol/Lipids/Triglycerides?
		16. Chronic chough, breathing problems, asthma, or hay fever?
		17. Tuberculosis or exposure to tuberculosis?
		Gastrointestinal
		18. Stomach or bowel problems?
		19. Liver problems (hepatitis, tumor, jaundice, etc)?
		20. Galbladder problems?
		Musculoskeletal
		21. Arthritis (pain in joints)?
		Skin
		22. Skin problems? If yes, what? __________ ☐ tattoo ☐ piercing
		Neurological
		23. Migraine/Headaches/Aura (diagnosed by MD/NP/PA)?
		Psychological
		24. Have you ever considered suicide?
		25. Depression requiring treatment? ☐ past ☐ present Other psychological problems?
		26. Eating disorder?
		Endocrine
		27. Thyroid problems?
		28. Diabetes? Pre-diabetes?
		29. Mono (mononucleosis)?
		Hematological/Lymphatic
		30. Anemia (low iron)?
		31. Sickle cell disease/trait?
		32. Blood clotting disorder?
		Birth Control
		33. Do you have a vasectomy?
		34. Have you ever gotten a partner pregnant?
		35. If born before 1970, did your mother take DES while pregnant with you?
		Allergy
		36. Are you allergic to any drug, medication, latex, or other substance? If yes, to what and type of reaction:
		Childhood Immunization
		38. Hepatitis A ☐ shot 1 ☐ shot 2
		39. Rubella
		40. Hepatitis B ☐ shot 1 ☐ shot 2 ☐ shot 3

Hospitalization and Surgeries

Year	Reason

Yes	No	Family History
		Are you adopted?
Has your biological family (parents, brothers, sisters) had any of the following?		
		Diabetes?
		Osteoporosis?
		Heart disease/heart attack/stroke before age 50?
		High cholesterol?
		Genetic problems?
		Blood clots?
		Cancer? If yes, please specify:
		Social History
		Are you being physically abused?
		Have you had sex for drugs or money?
		Has anyone forced you to have sex?
		Are you being sexually abused?
		Who helps you with your problems?
		Are you afraid of anyone: ☐ partner ☐ family member ☐ other?
		Genitourinary
		Painful/bloody ejaculation?
		Any concerns about your erections or premature ejaculation?
		Any pain during sex?
		Scrotal/Testicular (sac/balls) swelling or tenderness?
		Pain, swelling, discharge, or redness of penis?
		Urinary burning, frequent urination, or blood in urine?
		Hernia (groin area) or breast lump?
		STI/HIV Risks
		Have you received blood or blood products prior to 1978?
		Have you ever used street drugs? If yes, when/what?
		Have you ever shared needles (eg, injecting drugs, tattooing, piercing)?

Do you use condoms? ☐ some of the time ☐ all of the time ☐ never

Any history of sexually transmitted infection?
☐ chlamydia ☐ gonorrhea ☐ genital warts ☐ herpes
☐ syphilis ☐ PID ☐ HIV/AIDS

How many sexual partners do you have
Now? _______ Past year? _______ Lifetime? _______

Do you have sex with ☐ men ☐ women ☐ both

Do you have (check all that apply) ☐ vaginal ☐ oral ☐ anal sex?

Please check all that apply to your present partner(s):
☐ past or present use of blood or blood products
☐ use of street drugs
☐ multiple partners ☐ bisexual
Infected with ☐ HIV ☐ STI

Comments:

To the best of my knowledge, the information I have provided is correct and complete.

____
Client Signature Date

____
Staff Signature Date

Name ____________________ Date __________ Pt. # ______

Reason for Visit/Chief Complaint/History of Present Illness

Vital Signs

BP	Wt	Ht	Temp	Initials

STI Risks

- Change in partner since last exam? ☐ yes ☐ no
- With present partner wks/mos/yrs ____________
- Do you or your partner have other sexual partners? ☐ yes ☐ no ☐ unknown
- Partners: ☐ men ☐ women ☐ both
- ☐ vaginal ☐ oral ☐ anal
- ☐ barrier/condom usage

System	WNL	Other
General	☐ No acute distress, grossly WNL	
HEENT	☐ Grossly WNL	
CV	☐ RRR ☐ Murmurs	
RESP	☐ Clear to auscultation, equal breath sounds	
GI	☐ Abdomen soft/non-tender, no masses ☐ Liver/spleen non-palpable	
GU	☐ Breasts with no masses/discharge/tenderness ☐ no urethral discharge ☐ No CVAT ☐ Penis, no lesions, erythema or discharge ☐ Scrotum, no lesions, veins ☐ Epididymis, no nodules, swelling ☐ Hernias, no bulges ☐ Anus – no lesions ☐ Rectum – no nodules, mass ☐ Prostate – no irregularities, no tenderness, not enlarged, no hard areas	
MUSC	☐ back with no curvature ☐ extremities full ROM	
ENDO	☐ Thyroid NS/NT/equal bilateral	
SKIN	☐ Intact with no lesions ☐ Tattoo ☐ Piercing If yes, where?	
LYMPH	☐ No lymphadenopathy neck/axilla/groin	

Lab Tests Done

Outside

☐ GC/CT Urine/Urethral
☐ VDRL ☐ HIV ☐ HIV Conf ☐ Other ______________
☐ HEP B/C ☐ HSV Culture Blood

Inside

☐ HIV Rapid POS NEG ☐ FOB
☐ Urine Dip Glucose Protein Nitrites Leukocytes Blood
☐ Micro WBC _________ HPF Other ______________

Education Verbal and/or Written

- ☐ Abstinence
- ☐ Assessment/Plan discussed
- ☐ Breast health (BSE)
- ☐ CDC/ABC counseling
- ☐ Colon cancer
- ☐ Cholesterol management
- ☐ Contraception
- ☐ Domestic violence
- ☐ ETOH/Drugs
- ☐ Emergency service
- ☐ Exam/lab findings discussed
- ☐ HepB/MMR
- ☐ Infertility
- ☐ Medications prescribed
- ☐ Parental involvement
- ☐ Partner treatment
- ☐ Problem education
- ☐ Sexual abuse
- ☐ Sexual coercion
- ☐ STI/HIV education/safer sex
- ☐ Smoking Cessation
- ☐ Testicular health TSE
- ☐ UTI/Cystitis
- ☐ Weight control/diet/exercise
- ☐ Other _______________
- ☐ Staff Initials _______

Assessment

Plan

Clinician ________________________________ Date __________