

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 have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

I have been given information about the test(s), treatment(s), procedure(s), 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 understand that a new Pennsylvania law requires PPSP to give me written notification if a serious event compromising patient safety occurs under specific circumstances and that this notification will be sent to the mailing address listed on my contact sheet.

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 Southeastern Pennsylvania'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 voluntarily request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, or HIV antibody test, if I request it).

I hereby acknowledge receipt of Planned Parenthood Southeastern Pennsylvania'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 s/he read and understood same and had the opportunity to ask questions.

Signature of Witness _____

Date _____

Contact /Personal Information

Patient Number _____		Today's Date _____	
Name _____		Nickname _____	
First	Last	(optional)	
Address _____ / _____ / _____ / _____			
Street	Apt#	City	State Zip
Is it O.K. for us to contact you by mail at above address?		[] Yes	[] No
If yes, can we use a Planned Parenthood envelope?		[] Yes	[] No
Address for mail, if different from the one above:			
_____ / _____ / _____ / _____			
c/o Name	Street	Apt#	City State Zip
Can we use a Planned Parenthood envelope at this address? [] Yes [] No			
Your Telephone numbers			
Phone 1 (_____) _____ (home) (work) (cell) Best time to call? _____			
May we say "Planned Parenthood" to anyone who answers at this number? [] yes [] no; Code name: _____			
Phone 2 (_____) _____ (home) (work) (cell) Best time to call? _____			
May we say "Planned Parenthood" to anyone who answers at this number? [] yes [] no; Code name: _____			
Marital status: [] Married [] Not Married			
Social Security Number _____ - _____ - _____		[] Female [] Male	
Birth Date ____ - ____ - _____		Age _____	
Staff Use Only: ID Verified: [] yes [] no			
Referred By: How were you referred to us?			
[] Other Planned Parenthood Site	[] Drove/walked by Center	[] Family/Friend	[] Internet
[] Newspaper Ad	[] CHOICE Hotline	[] Doctor	[] Yellow Pages
[] Program done by PPSP	[] School/College	[] Other _____	
Sometimes Planned Parenthood likes to contact patients for your suggestions or to give you information. May we:			
[] Call to get your opinion over the telephone about your patient care experiences?			
[] Send you information about Planned Parenthood from any of its departments in a Planned Parenthood envelope?			
[] Please do not contact me for these purposes.			
Who can we contact if unable to reach you or in case of emergency? (This information is legally necessary):			
Name _____			
First	Last		
Address _____			
Bldg #	Street	Apt#	City State Zip
Phone Number (_____) _____			
Does this person know you are here [] Yes [] No Relationship _____			
Should we (1) use a Planned Parenthood envelope or (2) plain envelope (circle the appropriate number)			
Is it (1) OK to say Planned Parenthood to anyone who answers or (2) should we only use Planned Parenthood when speaking to the contact person? (Please circle appropriate number)			
What is the name of your family doctor?			

Patient Name _____

Patient Number _____

The information below is for statistical use only. No person will be excluded from services at Planned Parenthood Southeastern Pennsylvania based on duration of residency, citizenship, national origin, race, sexual orientation, marital status, religion, color, sex, method of referral, or contraceptive preference. With Census 2000, the Federal government introduced the option for choosing multiple races. Please choose from the lists below.

What county do you live in:

- Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA
- Other Pennsylvania County _____ (which county?) Other State _____ (which state?)

Race/ Ethnicity

- | | |
|---|--|
| <input type="checkbox"/> (04) Asian | <input type="checkbox"/> (21) Asian + Black + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (01) Black/African-American | <input type="checkbox"/> (22) Asian + Black + White |
| <input type="checkbox"/> (03) Native American/Alaskan Native | <input type="checkbox"/> (23) Asian + White + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (07) Pacific Islander/Native Hawaiian | <input type="checkbox"/> (24) Black + White + Native American/Alaskan Native |
| <input type="checkbox"/> (02) White | <input type="checkbox"/> (25) Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (08) Asian + Black | <input type="checkbox"/> (26) Black + White + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (09) Asian + Native American/Alaskan Native | <input type="checkbox"/> (27) White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (10) Asian + Pacific Islander/Native Hawaiian | <input type="checkbox"/> (28) Asian + Black + White + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (11) Asian + White | <input type="checkbox"/> (29) Asian + Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (12) Black + Native American/Alaskan Native | <input type="checkbox"/> (30) Asian + Black + White + Native American/Alaskan Native |
| <input type="checkbox"/> (13) Black + Pacific Islander/Native Hawaiian | <input type="checkbox"/> (31) Asian + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (14) Black + White | <input type="checkbox"/> (32) Black + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (15) Native American/Alaskan Native + Pacific Islander/Native Hawaiian | <input type="checkbox"/> (33) Asian + Black+ White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (16) White + Native American/Alaskan Native | <input type="checkbox"/> (05) Other or Unknown |
| <input type="checkbox"/> (17) White + Pacific Islander/Native Hawaiian | |
| <input type="checkbox"/> (18) Asian + Black + Native American/Alaskan Native | |
| <input type="checkbox"/> (19) Asian + Native American/Alaskan Native + Pacific Islander/Native Hawaiian | |
| <input type="checkbox"/> (20) Asian + White + Native American/Alaskan Native | |

Are you of Hispanic origin? yes no

What is your primary language? (if not English)

- | | | | | |
|--|------------------------------------|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Albanian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Hindi | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Ukranian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Creole | <input type="checkbox"/> Ibo | <input type="checkbox"/> Russian | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Bosnian/Croatian | <input type="checkbox"/> Ethiopian | <input type="checkbox"/> Laotian | <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> French | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog | <input type="checkbox"/> American Sign Language |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Greek | <input type="checkbox"/> Polish | <input type="checkbox"/> Turkish | |
| <input type="checkbox"/> Other _____ (which language?) | | | | |

Are you a student: yes no

What is the highest grade you have completed (do not include the one you are in now)? _____

If you are in high school, middle school, junior high or elementary school, what is the name of your school?

Current Birth Control Method:

- | | |
|--|--|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Patch (Ortho Evra) |
| <input type="checkbox"/> Cervical Cap | <input type="checkbox"/> Other |
| <input type="checkbox"/> Condom - female | <input type="checkbox"/> Spermicide |
| <input type="checkbox"/> Condom - male | <input type="checkbox"/> Sponge |
| <input type="checkbox"/> Condom and Spermicide | <input type="checkbox"/> Sterilization |
| <input type="checkbox"/> Depo-Provera | <input type="checkbox"/> None – pregnant |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> None – seeking pregnancy |
| <input type="checkbox"/> Implanon | <input type="checkbox"/> None – not currently sexually active |
| <input type="checkbox"/> IUD | <input type="checkbox"/> None – not at risk of becoming pregnant |
| <input type="checkbox"/> Natural Family Planning / Fertility Awareness | <input type="checkbox"/> None – not interested or undecided |
| <input type="checkbox"/> NuvaRing | |

Patient Name: _____ Patient Number: _____ Date: _____

ALL PATIENTS, PLEASE CHECK EACH BOX AND SIGN WHERE INDICATED:

- The information I have provided here is true and complete, to the best of my knowledge.
- I agree to provide documentation of any information I've reported here, if required.
- I may be assessed at each visit; my fee category may change if my circumstances or the fee scale changes.
- I understand PPSP will attempt to collect any unpaid balances.

Signature	Date
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FOR PATIENTS WITH COMMERCIAL, MA, OR SP HEALTH INSURANCE ONLY. PLEASE READ EACH ITEM CAREFULLY:

- I am responsible for paying for any services not covered by my insurance, including co-pays, deductibles, uncovered services, or those provided when my coverage was not in effect. These fees may be charged by PPSP and/or independent labs.
- I authorize direct payment on my behalf from my insurance carrier(s) to PPSP.
- I authorize PPSP to submit my insurance information to an independent laboratory for any testing that I receive.
- Correspondence from my insurance company may be sent to the address of record for the policy, and that it may indicate what services were provided.

➤ Are you under another person's insurance? If so, please provide their full name: _____

OR:

- DO NOT USE MY INSURANCE.** Using my insurance would breach my confidentiality, and I prefer to pay PPSP and/or an independent laboratory directly for all services I receive.

Signature	Date
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▶▶▶▶ STAFF USE ONLY ◀◀◀◀

Date	Weekly Inc-Hhold Size (ex. 425-02)	Fee Category (ex. A-B or T-D)	SP Status (ex. Applied, Active, Denied, Ineligible)	Comments	Staff Initials

Reason for no SP app: Age Inc Ins MA C/I Res Pr/St Ref ID

MEDICAL HISTORY - GYN

Patient Name: _____ **Age:** _____ **Medical Record #:** _____ **Date:** _____

New Patient **Established Patient**

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? Routine GYN Exam Problem Other _____

How do you identify? Female FTM Other _____

No **Yes**
 Are you receiving medical care with another health provider? Reason for visit(s) _____

Are you allergic to any medications, metals, foods, anesthesia or other products? List: _____

Are you currently taking any medications (including herbal remedies and vitamins)? List: _____

FAMILY HISTORY

No **Yes**
 I am adopted; my birth history is unknown.
 Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM) or Grandfather (GF) have any of the following?

No	Yes	Who	No	Yes	Who
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Breast disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack before age 50 _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Blood clots _____	<input type="checkbox"/>	<input type="checkbox"/>	Genetic disorder(s) _____

Circle: Father is living / deceased. Cause of death _____

Mother is living / deceased. Cause of death _____

PERSONAL HISTORY – Have YOU been diagnosed or treated for any of the following:

- | | No | Yes |
|-----|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> Genetic condition |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> High cholesterol / triglycerides |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> Heart disease / Murmur / MVP |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> Stroke / Blood clots |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> Anemia |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> Blood clotting disorder |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell anemia / trait |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> Breast problems / Surgery |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> Lung problems / Tuberculosis |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> Kidney / Bladder / Urinary Tract infection or problems |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> Recurrent vaginal infections |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> Pelvic infection / PID |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Pap smear |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> Cervical cryo, LEEP, Laser or Cone biopsy |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> Thyroid disease |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> Liver disease / Hepatitis / Mono |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> Gall bladder disease |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> Past surgery(s) |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> Past hospitalization(s) |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> Vaccination for Hepatitis B |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> Vaccination for Rubella / MMR |

REVIEW OF SYSTEMS – CONTINUED

- | | No | Yes |
|-----------------------------|--------------------------|---|
| Hematological: | | |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> Easily bruised |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> Varicose veins |
| Neurological: | | |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> Headaches (frequent / severe) / Migraine |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> Numbness / Sensory loss |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> Seizures |
| Respiratory / Chest: | | |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> Breast lump / discharge |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> Shortness of breath |
| Eyes: | | |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> Blurred / Double vision (Not corrected by glasses or contacts) |
| Gastrointestinal: | | |
| 36. | <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| 37. | <input type="checkbox"/> | <input type="checkbox"/> Bowel pain / Constipation / Diarrhea |
| 38. | <input type="checkbox"/> | <input type="checkbox"/> Rectal bleeding / Pain |
| Genitourinary: | | |
| 39. | <input type="checkbox"/> | <input type="checkbox"/> Vaginal discharge, itching or burning |
| 40. | <input type="checkbox"/> | <input type="checkbox"/> Frequency or burning with urination |
| 41. | <input type="checkbox"/> | <input type="checkbox"/> Pelvic pain |
| ENT: | | |
| 42. | <input type="checkbox"/> | <input type="checkbox"/> Ulcers / Sores in your mouth |
| Psychological: | | |
| 43. | <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| 44. | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| 45. | <input type="checkbox"/> | <input type="checkbox"/> Would you like a mental health referral today? |
| Skin: | | |
| 46. | <input type="checkbox"/> | <input type="checkbox"/> Rash or itching |

REVIEW OF SYSTEMS

- | | No | Yes |
|------------------------|--------------------------|--|
| Constitutional: | | |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> Generally healthy |
| Cardiovascular: | | |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> Swelling / Fluid retention in hands or feet |

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

HEALTH HABITS / SOCIAL HISTORY

- No Yes**
 Douches
 Self breast exams
 Smokes: _____ cigarettes per day.
 Alcohol intake: _____ drinks per week.
 Drug use: daily / weekly / monthly. Type _____
 Alcohol and/or drugs cause problems in your life?
 Others are concerned with your alcohol / drug habits?
 Afraid of your partner(s) / others?
 Parent(s) or guardian is aware of your visit today?
(Only answer if under age 18.)

SEXUAL HISTORY

- Age at first intercourse: _____
of sexual partners in last 30 days: _____
of sexual partners in lifetime: _____
Partner(s) – Check all that apply: Male Female Transgender Intersex
Kind of sex: (please indicate all that apply):
 Vaginal (Giver / Receiver)
 Anal (Giver / Receiver) Oral (Giver / Receiver)
Do you have pain or bleeding with sex? No Yes
Have you ever been forced to have sex? No Yes
Have you ever exchanged sex for money or something else
you wanted? No Yes
Do you consistently use condoms/dental dams for safer sex? No Yes
Do you plan children in the future? No Yes Undecided
Planning a pregnancy within the next year? No Yes Undecided

CONTRACEPTIVE HISTORY

- Current method of birth control: _____
How long have you used this method? _____
What other methods of birth control have you used?
 Pills _____ Diaphragm Rhythm/Natural
 Depo Provera _____ Cervical Cap Withdrawal
 Lunelle _____ Male condoms Abstinence
 Evra Patch _____ Female condoms Tubal sterilization
 Nuva Ring _____ Spermicide Vasectomy
 IUD _____ Norplant Implanon
What method, if any, do you want today? _____

I would like the following STI screening today:

- Chlamydia
 Gonorrhea
 HIV
 Syphilis

Patient Signature: _____

MENSTRUAL HISTORY

- Age when period started: _____
Periods are: Regular Irregular Painful
Flow is: Light Moderate Heavy
Periods come every _____ days.
Bleeding lasts _____ days.
When was the 1st day of your last period? _____
No Yes
 Was your last period normal?
 Do you think you might be pregnant?
 Do you ever miss periods?
 Do you ever have bleeding between periods?

Have you ever had the following?

- No Yes**
 Chlamydia Date last treated: _____
 Gonorrhea Date last treated: _____
 Herpes Date last treated: _____
 HPV/warts Date last treated: _____
 PID Date last treated: _____
 HIV Date last treated: _____
 Syphilis Date last treated: _____
 Trichomonas Date last treated: _____
 Currently experiencing itching, burning or unusual discharge?
 Did you douche, use a tampon, have bleeding or sex in the
last 3 days?

PREGNANCY HISTORY

- Never Pregnant
Age at first pregnancy (at time of conception): _____
of live births _____ Date(s) _____
of C-sections _____ Date(s) _____
of premature births _____ Date(s) _____
of miscarriages _____ Date(s) _____
of still births _____ Date(s) _____
of abortions _____ Date(s) _____
of ectopics _____ Date(s) _____

I would like information on the following:

- Birth Control Method(s) _____ Given (Staff Initials) _____
 Emergency Hormonal Contraception _____
 Preconception _____
 Perimenopause _____
 Smoking Cessation _____

Date: _____

Comments:

- STI Risk Assessment done.
 Safer sex and condom use reviewed.
 ECP discussed / Fact Sheet N0051 given.
 HIV pretest counseling done.
 Other _____
 Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: _____

Date: _____

Clinician Signature: _____

Date: _____