



REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE _____ PATIENT # _____ DATE OF BIRTH _____

NAME OF PATIENT _____ 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.

Please note that Planned Parenthood Southeastern Pennsylvania is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your 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 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 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 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 she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____ Date _____

CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____ Date _____

Relationship to patient _____ Date _____

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 _____

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? _____			
<i>May we say "Planned Parenthood" to anyone who answers at this number?</i> [] yes [] no; Code name: _____			
<i>May we text you? (charges may apply)</i> [] yes [] no			
Phone 2 (_____) _____ (home) (work) (cell) Best time to call? _____			
<i>May we say "Planned Parenthood" to anyone who answers at this number?</i> [] yes [] no; Code name: _____			
<i>May we text you? (charges may apply)</i> [] yes [] no			
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 | |
- 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 | |

Financial Assessment and Responsibility

Patient Name: _____ Patient Number: _____ Date: _____

The fees patients pay at Planned Parenthood are vital to allowing us to continue to provide services. However, there are a number of state, federal and private programs that allow us to discount the part of your services for which you are responsible. We ask the following questions to determine if you qualify for any discounts.

The financial information you provide will not result in denial of services.

If you choose not to answer the questions about your household income, we will not discount your services and you will be responsible for paying the full, non-discounted price today.

	Yes	No		Yes	No
I am female			I am pregnant OR have had my tubes tied		
I am between the ages of 18 and 44			I have private medical insurance* that covers contraceptives.		
I am a US Citizen or am a Permanent Resident with a Green Card			Submitting an insurance claim would violate my confidentiality or cause me harm		
I have a Social Security Number			I currently receive Medical Assistance OR SelectPlan for Women benefits		
I am a resident of Pennsylvania			I received Medical Assistance in the past 4 months		

I am employed. Yes No If Yes: I work _____ hours per week and earn \$ _____ per hour.
 2: I work _____ hours per week and earn \$ _____ per hour.
 3: I work _____ hours per week and earn \$ _____ per hour.

I am legally married and live with my spouse. Yes No OR I live with my partner Yes No
 His/her salary – *before taxes* – is: \$ _____ weekly every two weeks monthly annually

I have children: Yes No. If Yes: (#) _____ children and _____ live with me.
 I have financially dependent children / step-children. Yes No
 One or more of them is working pays rent. If yes to either or both, total is \$ _____ per month.

I pay for child / adult dependent care so that I can work. Yes No
 If Yes: The total I pay is \$ _____ per month.

I have the following other sources of income: [check all that apply]
 child support / alimony \$ _____ per month unemployment \$ _____ per month
 worker's comp / disability \$ _____ per month my children's income \$ _____ per month

I am supported by the following. Check and complete if applicable.
 Parent(s) or legal guardian(s) earns \$ _____ hourly weekly every two weeks monthly annually.
 Other (e.g. relative / roommate), please list: _____ earns \$ _____
 hourly weekly every two weeks monthly annually.

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 ALL PATIENTS WITH : PRIVATE INSURANCE (THAT YOU HAVE THROUGH YOUR JOB OR PAY FOR YOURSELF)
OR MEDICAL ASSISTANCE OR SELECTPLAN (INSURANCE PROVIDED BY THE STATE)**

PLEASE READ EACH ITEM CAREFULLY, CHECK EACH BOX AND SIGN WHERE INDICATED:

- 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 their: _____ / ____ / ____
Full Name Date of Birth

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"/> | Sickle cell anemia / trait |
| 9. <input type="checkbox"/> | <input type="checkbox"/> | Breast problems / Surgery |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Lung problems / Tuberculosis |
| 12. <input type="checkbox"/> | <input type="checkbox"/> | Kidney / Bladder / Urinary Tract infection or problems |
| 13. <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vaginal infections |
| 14. <input type="checkbox"/> | <input type="checkbox"/> | Pelvic infection / PID |
| 15. <input type="checkbox"/> | <input type="checkbox"/> | Colposcopy or abnormal pap smear |
| 16. <input type="checkbox"/> | <input type="checkbox"/> | Cervical cryo, LEEP, Laser or Cone biopsy |
| 17. <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| 18. <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| 19. <input type="checkbox"/> | <input type="checkbox"/> | Liver disease / Hepatitis / Mono |
| 20. <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder disease |
| 21. <input type="checkbox"/> | <input type="checkbox"/> | Past surgery(s) |
| 22. <input type="checkbox"/> | <input type="checkbox"/> | Past hospitalization(s) |
| 23. <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for Hepatitis B |
| 24. <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for Rubella / MMR |
| 25. <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for HPV |

REVIEW OF SYSTEMS

- No** **Yes**
- Constitutional:**
26. Generally healthy
- Cardiovascular:**
27. Swelling / Fluid retention in hands or feet

REVIEW OF SYSTEMS – CONTINUED

- No** **Yes**
- Hematological:**
28. Blood clots or blood clotting disorder
- Neurological:**
29. Headaches (frequent / severe) / Migraine
30. Numbness / Sensory loss
31. Seizures
- Respiratory / Chest:**
32. Breast lump / discharge
33. Shortness of breath
- Eyes:**
34. Blurred / Double vision (Not corrected by glasses or contacts)
- Gastrointestinal:**
35. Abdominal pain
36. Bowel pain / Constipation / Diarrhea
37. Rectal bleeding / Pain
- Genitourinary:**
38. Vaginal discharge, itching or burning
39. Frequency or burning with urination
40. Pelvic pain
- ENT:**
41. Ulcers / Sores in your mouth
- Psychological:**
42. Mental health problem, learning disability
43. Would you like a mental health referral today?
- Skin:**
44. Rash or itching

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: _____

Date: _____

Comments:

LNMP: _____
Last UPI: _____

Interviewer Signature: _____

Date: _____

Clinician Signature: _____

Date: _____

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: _____
 - Trichomoniasis Date last treated: _____
 - Currently experiencing itching, burning or unusual discharge?
 - Did you douche, use a tampon, have bleeding or sex in the last 24 hours?

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) _____
No Yes
 Are you currently breast-feeding?

I would like information on the following:

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

- Visit steps explained
- STI risk assessment done
- Safer sex and condom use reviewed
- Discussed risks & benefits of _____
- ECP discussed / CIIC N0051 given
- Other _____
- Pt. urged to discuss visit with parent or guardian

Additional History for Women 40 and Over

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

Family History

No Yes Unsure

- Age mother and/or sisters went through menopause
 Osteoporosis

Personal History Have you ever had or do you have:

No Yes Unsure

- Difficulty holding urine _____
 Hot flashes _____
 Night sweats _____
 Depression/mood swings _____
 Anxiety _____
 Heart palpitations _____
 Sleeplessness _____
 Dryness of the vagina _____
 Change in sexual desire _____
 Pain or difficulty with urination _____
 Change in bowel habits including bloody or tarry stools _____
 Osteoporosis or broken bones after age 35 _____
 Mammogram: Date of last _____, result _____
 Other problems _____

Notes

Staff Signature: _____