Planned Parenthood®
of Southern New Jersey

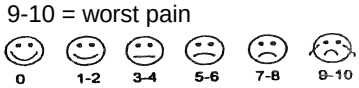
FOR OFFICE USE ONLY	
CHART #_____	FEE_____
IV: YES_____	NO_____
TITLE_____	GROUP_____

CLIENT VISIT FORM **ON-LINE**

Please fill in all blanks. Please ask if you have any questions. <u>All information is confidential.</u>

Date_____Reason for visit_____

Name_____Date of Birth_____ Age_____
SS#_____ Phone # _____
Address_____City_____State_____Zip_____
Marital status: single___ married___ divorced___ separated___ widowed____
Can we write/call you identifying ourselves as Planned Parenthood? yes___ no___
If answer is no, our contact code is "MAXINE"
Emergency contact: Name:_____*Relationship*_____
Address_____Phone_____
What is your monthly income? _____ How many people does this support?_____
Is your income from a Job – Unemployment—Partner ---Husband – Parents --Other
How many years of school have you completed?___
Are you a student now? no___ yes___ Which: High School___ College___ Other___
Do you currently smoke cigarettes? no___ yes___ , how many a day?_____
Have there been any changes in your family's medical history since your last visit? no___ yes ___
If yes, please explain_____
What is your present form of birth control (including condoms)_____
First day of your last period started_____
Was this a regular period? __ yes __no, if no, why? _____
*# births*_____ *# abortions*____ *# miscarriages*_____

Review of Systems	NO	YES	If Yes, Please describe as needed below
Vaginal discharge/itch/odor			
Painful sex / pain with urination			
Severe menstrual cramps or severe abdominal pain			
Breast lump or breast discharge			
Any skin changes/ more acne			
Unprotected sex since last period			
Any chest pain/ trouble breathing			
Hospitalizations/ surgeries			
Severe headaches/ blurred or double vision / Leg or arm numbness			
Currently on medication prescribed by Dr. or taking over the counter medications			
Physical or sexual abuse, incest			
Alcohol or drug use			
Sexually transmitted diseases, including hepatitis (A,B,C)			
Are you in any pain today? Where is the pain?			Please circle 0=no pain 9-10 = worst pain  Location:

I hereby request that a person authorized by PPSNJ provide appropriate evaluation, testing, and treatment, including a birth control method, if requested.
Client signature:_____ **Date:**_____

Staff signature: _____ Date: _____

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