Planned Parenthood Association of the Mercer Area

Patient Registration Form
Regestación Para Paciente

Patient#/# del paciente_____

Please complete the following form. All the information is confidential.
Por favor complete la hoja seguida. Toda la información es confidencial.

First Name
Primer Nombre _____

Last Name
Apellido _____

Address
Dirección _____

County
Condado _____

City
Ciudad _____

State
Estado _____

Zip
Código Postal _____

SS#
de Seguro Social _____-____-_____

Date of Birth
Fecha de Nacimiento _____/_____/_____

House Hold Income
Ingreso de la casa $_____.____

Yearly ❑ Anual
Monthly ❑ Mensual
Weekly ❑ Semanal

Family Size
Cuantos son en tu Familia _____

How many are children(s)
Cuantos son niño(s) _____

Home phone
Numero de teléfono (____)____-_____

Work phone
Numero del trabajo (____)____-_____

Emergency contact Phone number
Numero de contacto de emergencia (____)____-_____

Emergency contact Name
Nombre del contacto de emergencia _____

Please check one of the four ways you want to receive you mail from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir corresponda de nosotros (PPAMA)

Full return address ❑ Dirección completa dé retorno
Street address ONLY ❑ Solamente la dirección de la calle
NO return address ❑ SIN dirección
NO mail ❑ Ninguna respeta

Please check one of the four ways you want to receive phone calls from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir llamas de nosotros (PPAMA)

Saying Planned Parenthood ❑ Diciendo Planned Parenthood
Saying Doctor's Office ❑ Diciendo oficina de doctor
Saying it's a friend ❑ Diciendo que es una amiga
NO calls ❑ Ninguna llamadas

Please check all that apply
Por favor marque todo que aplica

Sex — Female / Male
Sexo - ❑ Femenino ❑ Masculino

Race — American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White
Raza - ❑ Indio Americano o Nativo de Alaska ❑ Asiático ❑ Moreno o Americano Africano ❑ Nativo Hawaiano o Isleño Pacifico ❑ Blanco

Hispanic — Yes – Hispanic or Latin / Not – Hispanic nor Latin / Unknown
Hispano - ❑ Si – Hispano o Latino ❑ No – Hispano o Latino ❑ No sabes

Marital Status — Divorced / Living together / Married / Separated / Single / Widowed
Estado Marital - ❑ Divorciada ❑ Viven juntos ❑ Casada ❑ Separada ❑ Soltera ❑ Viuda

Referral — Family o Friend / Hospital / Hot Line / Media / Other patient / Phone book
Referido - ❑ Familia o Amiga ❑ Hospital ❑ Línea Abierta ❑ Medio de comunicación ❑ Otra paciente ❑ Libro de teléfono
Outreach / Private Doctor / Welfare
❑ Alcance ❑ Médico privado ❑ Welfare

Language — English / Other
Idioma - ❑ Ingles ❑ Otro _____
Interpreter Needed
❑ Necesito un Interprete

Student — Yes / No
Estudiante - ❑ Si ❑ No
Highest grade f school you completed
Grado mas alto que ha completado en la escuela _____

Planned Parenthood Association of the Mercer Area

MEDICAL HISTORY FORM FOR ECPS WITH A DEFERRED EXAM

Date:_____

Name: _____
Chart #: _____
Date of Birth: _____

Brief Medical History

Have you ever had:

Stroke?	☐Yes	☐No
Blood Clots?	☐Yes	☐No
Heart attack or chest pains?	☐Yes	☐No
Cancer?	☐Yes	☐No
Liver tumor or disease?	☐Yes	☐No
Diabetes?	☐Yes	☐No
Seizures?	☐Yes	☐No
High blood pressure?	☐Yes	☐No
High cholesterol?	☐Yes	☐No
Bad headaches?	☐Yes	☐No
Breast cancer or lumps in your breast?	☐Yes	☐No
Serious illness?	☐Yes	☐No
Are you over 35?	☐Yes	☐No
Do you smoke?	☐Yes	☐No

Has a parent, brother or sister had a heart attack before age 55? ☐Yes ☐No

Current birth control method _____

Have you had sex without birth control since your last period? ☐Yes ☐No

If yes……Date_____ Time_____

Did anyone force you to have sex? ☐Yes ☐No

Date of last menstrual period _____ Was it a normal period? ☐Yes ☐No

Have your periods been abnormal or irregular lately? ☐Yes ☐No

If yes, describe _____

Do you think you are pregnant now? ☐Yes ☐No

Are you nursing a baby? ☐Yes ☐No

If pregnant before, please list dates of:

Live Births _____ Abortions _____ Ectopics _____ Miscarriages _____

Other _____

General Health Questions

When was your last physical exam? _____ Was it normal? ☐Yes ☐No

When was your last Pap smear? _____ Was it normal? ☐Yes ☐No

When was your last breast exam? _____ Was it normal? ☐Yes ☐No

When was your last mammogram? _____ Was it normal? ☐Yes ☐No

Do you have any abnormal or unusual vaginal discharge? ☐Yes ☐No

Have you had a change of sexual partners in the last 6 months? ☐Yes ☐No

Patient Signature: _____ Date: _____

FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE

Name: _____
Chart #: _____
Date of Birth: _____

Assessment

Weight_____ Blood Pressure _____

If Indicated, laboratory test result: Type of Pregnancy Test: _____ Result: _____

GC/Chlamydia Testing done: ☐Yes ☐No Result: _____

□Yes □ No	Patient stated that she wants Emergency Contraceptive Pills (ECPs).
□Yes □ No	Patient was told about available options to ECPs.
□Yes □ No	Information on contraceptive methods given.
□Yes □ No	Patient was counseled per PP protocol regarding ECP
□Yes □ No	Patient was given the Client Information for Informed Consent (CIIC): ECPs., with instructions for use completed on form.
□Yes □ No	Complete the Request for Medical Services Method Specific form, signature obtained
□Yes □ No	Patient appropriate candidate for ECPs
□Yes □ No	ECP given

Notes:

Staff Signature: _____ Date: _____

ECP ORDER:
□ Plan B #2 Tabs □ (2) tabs PO now □ Prophylactic PRN w/in 120 hrs unprotected IC Refill x____ Rx given □
□ Plan B #2 Tabs □ (1) tab PO now (1) tab in 12 hours □ Prophylactic PRN w/in 120 hrs unprotected IC
Refill x____ Rx given □
□ Other *(directions and prophylaxis regime to be written here.)*

_____ _____
Clinician Signature Date

☐ New Patient Packet of Information given

Client to return: _____

Staff Signature: _____ Date _____