FAMILY PLANNING AND REPRODUCTIVE HEALTH FEMALE FLOW SHEET

First Last Middle

Address:

Phone

Patient Number

Date of Birth (MM/DD/YYYY)

1. Date: _____

Reason for visit: _____

Age: _____

2. Allergies:

3. Menses LMP Date _____ Normal? ☐ Yes ☐ No

4. Adolescent Counseling

☐ Adolescents must be told services are confidential, family involvement is encouraged and resisting sexual coercion is discussed. R

If family participation is not encouraged why not?

_____

☐ Adolescents must be advised of what information must be reported due to mandatory reporting laws and ho w it will be handled if necessary. **R**

☐ Adolescents should be provided intervention to prevent initiation of tobacco use. **R**

5. Reproductive Life Planning

Do you want to have more children? ☐ Yes ☐ No ☐ Unsure

If yes when would you like to become pregnant?

☐ ≤ 1 year ☐ 1-5 years ☐ > 5 years

How important is it to you to prevent pregnancy (until then)?_____

Date of last pregnancy_____

☐ IF POSTPARTUM advised to delay future pregnancy for 18 mos.- 5 years

6. Current Method:

☐ OCP (type)_____ ☐ Patch ☐ Ring ☐ FABM

☐ Depo (date of last shot)_____ ☐ Condoms ☐ BTL

☐ Implant (date inserted)_____

☐ IUD (date inserted)_____

☐ Other ☐ None Satisfied? ☐ Yes ☐ No

Desired method changed? ☐ Yes ☐ No

Unprotected Intercourse in Past Five Days: ☐ Yes ☐ No

7. Ht: Wt: BMI: B/P:

8. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)

1. Do you have sex with? ☐ Men only ☐ Women only ☐ Both men and women ☐ Not sexually active
2. In the past three months, how many partners have you had sex with?

   _____
3. In the past 12 months, how many partners have you had sex with?

   _____
4. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? ☐ Yes ☐ No
5. What do you do to protect yourself from STDs and HIV?

   _____

   _____
6. What ways do you have sex? ☐ vaginal ☐ oral ☐ anal
7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral, or anal sex? ☐ Yes ☐ No
8. Have you ever had an STD? ☐ Yes ☐ No

   If yes, which STD(s) and when?_____

   _____
9. Have any of your partners had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others)

   ☐ Yes ☐ No If yes, which STD(s) and when?_____

   _____
10. Have you or any of your partners ever injected drugs? ☐ Yes ☐ No
11. Have you or any of your partners exchanged money or drugs for sex? ☐ Yes ☐ No
12. Have you had a HIV test? ☐ Yes ☐ No If so, when?

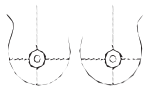
    _____
13. Do you wish to have a HIV test today? ☐ Yes ☐ No

9. MENTAL HEALTH HISTORY

1. During the past two weeks, have you often been bothered by either of the following two problems?
   Feeling down, depressed, irritable or hopeless ☐ Yes ☐ No or
   Little interest or pleasure in doing things ☐ Yes ☐ No
2. Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No
3. In the past year, have you been slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No

10. System Review:	Code	Comments
Weight loss or gain		
Headache		
Blurry or double vision/flashing lights		
Swollen glands in neck		
Coughing up blood/SOB/Wheezing		
SOB with activity/difficulty breathing/lying down/chest pain or discomfort		
Swelling		
Breastfeeding		
Breast lumps/pain/discharge		
Yellow eyes or skin		
Rectal bleeding		
Vaginal discharge/ pain/burning/itching		
Douching/painful coitus unexplained Bleeding from vagina		
Frequency, urgency, burning/ blood in urine		
Calf pain with walking		
Ease of bruising or bleeding		
Rashes/growths/lesions		
Other problems		

11. Physical Exam:	Code	Comments
Skin		
HEENT		
Neck/Thyroid		
Lungs		
Heart		
Breasts/Nipples		
Abdomen		
Musculo Skeletal		
Extremities		
Vulva		
Bladder/urethra		
Perineum		
Uterus		
Vagina		
Cervix		
Adnexa		
Rectum		



IUD strings seen? ☐ Y ☐ N

Comments:

12. Labs:		Comments:
Cervical Cytology	☐ Y ☐ N	
Wet Prep	☐ Y ☐ N	
GC	☐ Y ☐ N	
Chlamydia	☐ Y ☐ N	
HIV	☐ Y ☐ N	
Pregnancy Test	☐ Y ☐ N	
Syphilis	☐ Y ☐ N	
Glucose	☐ Y ☐ N	
Hepatitis C	☐ Y ☐ N	
Other Labs: _____		

13. Education/Counseling: Information needed to: (check all that apply)

☐ Make informed decision about family planning **R**

☐ Use specific methods of contraception and identify adverse effects **R**

☐ Reduce risk of transmission of STDs and HIV based on sexual risk assessment **I**

☐ Promote daily consumption of multivitamin with folic acid if capable of conceiving **R**

☐ Provide reproductive life planning counseling **R**

☐ Review immunization history and inform client of recommended vaccine per CDC's ACIP Guidelines and offer, as indicated, or refer to other providers **R**

☐ Provide preconception counseling **R**

☐ Understand BMI greater than 25 or less than 18.5 is a health risk (weight management educational materials to be provided to clients if client requests with a BMI of greater than 25 or less than 18.5) **I**

☐ Stop tobacco use, implementing the 5A counseling approach **I**

☐ Encourage biennial mammogram for women ≥ 50 & < 50 if conditions support **I**

☐Provide achieving pregnancy counseling **I**

☐ Provide basic infertility counseling **I**

☐ Referred for Hepatitis C screening if at high risk for infection for hepatitis C virus (HCV) and one-time screening for hepatitis C virus (HCV) infection for all persons 18-79 years of age. **I**

14. Client Method Counseling: Individual dialogue covers:

☐ Results of physical assessment and labs (if performed) **R**

☐Contraceptive counseling/education provided

☐ Provide Emergency Contraception Counseling **R**

☐ Adolescents counseled on abstinence, LARC, and condoms **R**

☐ How to discontinue the method selected and information on back up method used **R**

☐ Typical use rates for method effectiveness **R**

☐ How to use the method consistently and correctly **R**

☐ Protection from STDs if non-barrier method is chosen **I**

☐ Warning signs for rare but serious adverse events and what to do if they experience a warning sign (including emergency 24-hour number, where to seek emergency services outside of hours of operation) **R**

☐ When to return for a follow up (planned return schedule) **R**

☐ Appropriate referral for additional services as needed **I**

☐ Yes ☐ No Teach Back Method used

15. Assessment/Plan/Method/Referrals:

☐ Emergency Contraception Offered 1) If unprotected intercourse in past five days and/or 2) Prophylactically as indicated.

☐ If positive pregnancy test result, counseling and referral provided per policy, and Presumptive Eligibility completed if applicable per policy.

☐ Contraceptive Method patient chose at the close of the visit

☐ OCP (type):_____

☐ Depo ☐ Condoms ☐ Patch ☐ Ring

☐ IUD (type):_____ ☐ Implant

☐ BTL ☐ FABM (type):_____ ☐ None

☐ Declined all methods

☐ Other _____

Nurse Interviewer: _____

Nurse Dispensing if Different from Interviewer: _____

Examiner Signature: _____

16. (These signatures attest that ROS, health history form and required education/counseling have been reviewed and discussed with client)