

FAMILY PLANNING AND REPRODUCTIVE HEALTH
BIOLOGICAL FEMALE FLOW SHEET

First	Last	Middle	7. *Ht:	*Wt:	BMI:	*B/P:
Address:			8. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)			
Phone			1. * Sexual Orientation? <input type="checkbox"/> bisexual <input type="checkbox"/> lesbian, gay or homosexual <input type="checkbox"/> straight or heterosexual <input type="checkbox"/> other, something else <input type="checkbox"/> unknown			
Patient Number			2. In the past three months, how many partners have you had sex with? _____			
Date of Birth			3. In the past 12 months, how many partners have you had sex with? _____			
	(MM/DD/YYYY)		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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1. Date: _____ Reason for visit: _____ Age: _____			5. What do you do to protect yourself from STDs and HIV? _____ _____			
2. Allergies (reaction):			6. What ways do you have sex? <input type="checkbox"/> vaginal <input type="checkbox"/> oral <input type="checkbox"/> anal			
3. Menses LMP Date _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral, or anal sex? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Adolescent Counseling <input type="checkbox"/> 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? _____			8. Have you ever had an STD? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which STD(s) and when? _____ _____			
<input type="checkbox"/> Adolescents must be advised of what information must be reported due to mandatory reporting laws and how it will be handled if necessary. R			9. Have any of your partners had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which STD(s) and when? _____ _____			
<input type="checkbox"/> Adolescents should be provided intervention to prevent initiation of tobacco use. R			10. Have you or any of your partners ever injected drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Reproductive Life Planning (pregnancy intention) *Do you want to have (more) children in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> I'm ok either way How important is it to you to prevent pregnancy (until then)? _____			11. Have you or any of your partners exchanged money or drugs for sex? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of last pregnancy _____ <input type="checkbox"/> IF POSTPARTUM advised to delay future pregnancy for a minimum of 6 months. Counseled risk vs. benefits of a repeat pregnancy sooner than 18 mos.			12. Have you had an HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____			
6. *Contraceptive Method at Intake: _____ (see List of methods provided on page 4) *If no method at intake, why? <input type="checkbox"/> Abstinence <input type="checkbox"/> Same sex partner <input type="checkbox"/> Other <input type="checkbox"/> Sterile for non-contraceptive reasons <input type="checkbox"/> Seeking Pregnancy <input type="checkbox"/> Pregnant Satisfied? <input type="checkbox"/> Yes <input type="checkbox"/> No Desired method changed? <input type="checkbox"/> Yes <input type="checkbox"/> No Unprotected Intercourse in Past Five Days: <input type="checkbox"/> Yes <input type="checkbox"/> No			13. Do you wish to have a HIV test today? <input type="checkbox"/> Yes <input type="checkbox"/> No			

*Indicates item to be extracted to LHD-HSA for Family Planning Annual Report (FPAR)

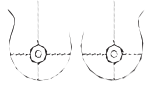
9. MENTAL HEALTH HISTORY

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
Unexplained weight loss or gain		
Headache		
Blurry or double vision/flashing lights in vision		
Shortness of breath/difficulty breathing		
Numbness or tingling in extremities		
Swelling in extremities		
Lactating		
Breast lumps/pain/discharge		
Rectal bleeding		
Vaginal discharge/pain/burning/itching		
Unexpected and/or heavy vaginal bleeding		
Painful sex		
Urinary frequency, urgency, burning/blood in urine		
Easy bruising or bleeding		
Rashes/growths/lesions		
Other problems		

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

Comments:



IUD strings seen? Y N



12. Labs:	Comments:
*Cervical Cytology <input type="checkbox"/> Y <input type="checkbox"/> N	
*HPV <input type="checkbox"/> Y <input type="checkbox"/> N	
Wet Prep <input type="checkbox"/> Y <input type="checkbox"/> N	
*GC <input type="checkbox"/> Y <input type="checkbox"/> N	
*Chlamydia <input type="checkbox"/> Y <input type="checkbox"/> N	
*HIV <input type="checkbox"/> Y <input type="checkbox"/> N	
Pregnancy Test <input type="checkbox"/> Y <input type="checkbox"/> N	
*Syphilis <input type="checkbox"/> Y <input type="checkbox"/> N	
Glucose <input type="checkbox"/> Y <input type="checkbox"/> N	
Hepatitis C <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Referred for testing	
Other Labs: _____	

13. Education/Counseling: Information needed to make informed decisions regarding family planning: (check all that apply)

- Use specific methods of contraception and identify adverse effects (at initiation of a contraceptive method) **R**
- Reduce risk of transmission of STDs and HIV based on sexual risk assessment **I**
- Promote daily consumption of folic acid supplement 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 30 or less than 18.5 is a health risk (weight management educational materials to be provided to clients if patient requests) **I**
- Stop tobacco or Electronic Nicotine Delivery Systems (ENDS) use, implementing the 5A counseling approach **I**
- Encourage mammograms in accordance with the nationally recognized guidelines the agency has chosen to follow and incorporated into agency policy/procedure/protocol. **I**
- * Provide achieving pregnancy counseling **I**
- Provide basic infertility counseling **I**

14. Client Method Counseling: Individual dialogue covers:

- Results of physical assessment and labs (if performed) **I**
- * Client centered contraceptive counseling/education provided **R**
- Provide Emergency Contraception Counseling, if pregnancy is not desired **I**
- Adolescents must be counseled on abstinence, condoms, LARC, and other methods of contraception **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 **R**
- Teach Back Method used Yes No

15. Assessment/Plan/Method/Referrals:

- Emergency Contraception Offered 1) If unprotected intercourse in past five days and pregnancy is not desired, as well as. 2) Prophylactically as indicated.
- If positive pregnancy test result, information and referral provided per policy, and Presumptive Eligibility completed if applicable per policy.

*Contraceptive Method at Exit:
(see List of methods provided on page 4)

*If no method at exit, why?
 Abstinence Same sex partner Other Sterile for non-contraceptive reasons Seeking Pregnancy Pregnant

*How was method dispensed? (If method provided)
 Provided on site Referral Prescription

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)

List of Contraceptive Methods

Implantable rod
IUD with Progestin
IUD copper
IUD unspecified
Female sterilization
Vasectomy
Injectables
Combined oral contraceptive pills
Progestin only contraceptive pills
Contraceptive patch
Vaginal ring
Male condom
Diaphragm or cervical cap
Female condom
Withdrawal
Spermicide
Contraceptive Gel
Sponge
Fertility awareness-based methods
Lactational amenorrhea method
Male relying on female method
Emergency contraception
Decline to answer
None