Chart # _____
Careful Contact? Yes____ No____

CLIENT INFORMATION SHEET

Print Name_____ Birthdate_____ Age_____
Last First Middle Maiden

Address_____ Home # _____ Best time
Cell # _____ to call _____

_____ SS#____ - ____ -____
City State Zip Code County

I work: ☐ Full time ☐ Part time ☐ I do NOT work Place of Work and/or School_____

Work Phone_____ Best time to call_____ ☐ E-mail address_____

Emergency Contact:_____ Phone #_____

I live with: ☐ Spouse/Partner ☐ Parents ☐ Others ☐ Alone How many people live in your home? _____

We must be able to contact you to give you test results. Please check **all** the ways we may contact you:

☐ Call home ☐ Call work ☐ Call Home as "Heidi" ☐ Call Cell Phone ☐ Mail at home ☐ Plain envelope ☐ E-mail ☐ Other

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Because we receive federal funds, we must collect this information about you:

You may check more than one: ☐ White ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ Unknown

Please check one: Origin: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Are you covered by public health insurance such as Medicaid, Medicare, CHIP, TRICARE/CHAMPUS, CHAMPVA or Kids Connection? ☐ Yes ☐ No ☐ Unknown

Are you covered by private health insurance? ☐ Yes ☐ No ☐ Unknown

Does your insurance cover Family Planning? ☐ Yes ☐ No ☐ Unknown

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☐ I wish to apply for reduced fees and will give staff complete and honest information about my income.

☐ I do NOT wish to apply for reduced fees. ☐ Bill my insurance. ☐ Bill Medicaid # _____

LIST ALL SOURCES OF FINANCIAL SUPPORT (show all amounts before any deductions)

Source Of Income:
- Your employment (pay stubs) Monthly Amount:_____
- Spouse/partner or Parent employment _____
- Dependent Children (AFDC/ADC) _____
- Child Support and/or Alimony _____
- SSI, Unemployment compensation _____
- Social Security, pension, railroad retirement, insurance & annuity payments _____
- Dividends, interest, rental income, trust funds _____
- Other sources (tips, allowances, etc.) _____

How many people including yourself, does this income support? _____

Cost for services is based on a sliding fee scale. You are responsible for any fees that there may be.

Patient Signature_____ Date_____

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

****

FOR OFFICE USE ONLY: Staff Initials/Date _____

VERIFIED TOTAL MONTHLY INCOME_____ INCOME CODE: A(1) B(2) C(3) D(4) E(5)

3rd party: Ins Medicaid EWM

FEMALE MEDICAL HISTORY

NAME_____ **AGE** _____ **DOB** _____

Marital Status S M D W Separated Living with someone **Allergies**_____

Hospitalizations/Surgery_____ **Current Meds**(to include over the counter medications)____

Major Illnesses/Injuries_____ _____

Reason for today's visit:_____

Date of Last Pap Smear:_____History of Abnormal Pap? Y N Unknown, if yes what type of treatment did yo have?_____

Do you use: Tobacco products? Y N, If yes type/amount per day_____ Alcohol/drugs? Y N, if yes type/amount_____

Have You had: German Measles (Rubella)? Yes No Vaccinated Unknown Normal Childhood Vaccinations? Y N Unknowr

Did your mother take DES(a medication to prevent miscarriages) when she was pregnant with you? Yes No

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Family History: Has any member of your family (parents, siblings, grandparents) had any of the following? Please Mark all tha apply and state relationship:

❑Check here if you do not know your biological family histor

❑Diabetes_____ ❑Stroke_____ ❑Heart Disease_____ ❑Blood Clots_____

❑High Blood Pressure_____ ❑High Cholesterol_____ ❑Sickle Cell Anemia_____

❑ Cancer (if yes, type and relationship)_____

❑Birth Defects/Genetic Diseases (if yes, type and relationship)_____ ❑Other_____

Past Medical History: Do you have, or have you ever had (Check all that apply):

GENERAL
- ❑Frequent or Severe Headaches
- ❑Unexplained Weight loss
- ❑Dizziness/Fainting
- ❑Seizures/Epilepsy/Convulsions
- ❑Skin Disorders
- ❑Leg pain/tenderness, swelling
- ❑Joint Pain
- ❑Recent Chills/Fever
- ❑Weight Problems

HEENT
- ❑Vision Problems (blurring/double vision, spots)
- ❑Hearing Problems
- ❑Difficulty Swallowing
- ❑Runny Nose

LUNGS
- ❑Chronic Cough
- ❑Hay Fever
- ❑Asthma
- ❑TB

BLOOD
- ❑Transfusions/Exposure to Blood Products
- ❑Anemia
- ❑High Cholesterol
- ❑Blood Clots
- ❑Unusual Bruising
- ❑Blood Disorders
- ❑Injectable Drug Use

PSYCHOSOCIAL
- ❑Depression/Anxiety
- ❑History of Abuse
- ❑Suicidal Thoughts
- ❑Highest Grade Completed

ENDOCRINE
- ❑Diabetes
- ❑Thyroid Disorder
- ❑Increased Thirst

HEART
- ❑Chest pain
- ❑Difficulty Breathing
- ❑High Cholesterol
- ❑Mitral Valve Prolapse
- ❑Heart Murmur
- ❑High Blood Pressure
- ❑Stroke

ABDOMEN
- ❑Gallbladder Disease
- ❑Gastric Ulcers
- ❑Heartburn
- ❑Pain

LIVER
- ❑Hepatitis
- ❑Jaundice
- ❑Mononucleosis

CANCER ❑TYPE_____

BREASTS
- ❑Lump
- ❑Nipple Discharge

BOWELS
- ❑Constipation/Diarrhea
- ❑Blood in Stool
- ❑Rectal Pain/Bleeding

❑Kidney/Bladder Problems or Infections
❑Blood in Urine
❑Nighttime Urination
❑Pain, burning, difficulty or frequent urination
❑Sores/Bumps/Rash in genital area
❑Ovarian Cysts
❑Polycystic Ovarian Syndrome
❑Pain/bleeding with intercourse
❑Endometriosis
❑Genital Cancer, if yes type_____

MENSTRUAL HISTORY

First Day of Last Menstrual Period_____
Was it normal? Yes No
If you are on birth control, do you bleed "on time"? Yes No
Do you have abnormal bleeding? Yes No
What age were you when you had your first period? _____
How often do you have a period? Every____days.
How many days do you bleed?_____
Is your bleeding: Light Medium Heavy
Do you have cramps with your period: Mild Moderate Severe
Do you have Premenstrual Syndrome(PMS) Yes No

CONTRACEPTIVE HISTORY

Do you plan future children? Yes No Undecided
Are you and your partner(s) currently using birth control?
❑Yes ❑No ❑Unsure, if yes, which type(s)?_____
What types have you used before?_____
How long did you use it for?_____
When did you stop using it and why?_____
Have you ever had an adverse reaction to a birth control method? Yes No, if Yes, what:_____
Do you want more information about birth control? Yes No

Other Concerns/Pertinent History:_____

Are you currently Sexually Active Yes No
Lifetime Sexual Partners:_____
Age of First Intercourse:_____
Are your current and past partners: Male Female Both
How many current sexual partners do you have?_____
Does your current sexual partner have STI symptoms? Yes No
Has your current or past sexual partner(s) had an STI or HIV?
Yes No Unknown, If yes type_____
Has your current or past sexual partner(s)had multiple partners or was bisexual(having sex with men and women)? Yes No
Do your current or past sexual partner(s) inject drugs? Yes No
Have you had more than one sexual partner in the last 6 months? Yes No
What types of Sex do you have: Vaginal Oral Anal
❑Sexually Transmitted Infection(Gonorrhea,Chlamydia,Warts,Herpes,Hepatitis)
Type:_____
❑Do you have HIV? Yes No Unknown
Do you wish to be tested for HIV? Yes No
Have you ever been forced into an activity you did not want to do? Yes No
Do you have any questions about human sexuality?(ie. Orgasm, lubrication)_____

PREGNANCY HISTORY

How many times have you been pregnant?_____
How many deliveries___ miscarriages____Terminations____
How many living children do you have?_____
How many stillbirths have you had?_____
Have you ever had a tubal pregnancy?_____
Have you placed any children for adoption?_____
Did you have any complications with pregnancy/delivery?_____

Do you plan future children? Yes No Undecided

NUTRITION

How many servings of the following do have per day: Fruits_____Vegetables_____Nuts/Beans_____
Eggs/Meats_____Milk/Dairy_____Caffeine_____

EDUCATION:

Physical Exam ❑
Emergency Information ❑
STI's/HIV ❑
Female/Male Anatomy ❑ NA ❑
Exercise ❑ NA ❑
Adolescent Ed. ❑ NA ❑
(to include Abstinence, Family involvement, Contraception, safer sex practices, & sexual coercion)

Condom Fact Sheet ❑
Smoking Cessation ❑
Alcohol/Drug Abuse❑ NA ❑
Abuse ❑ NA ❑
Contraceptive Options ❑
(to include NFP, effective use of methods, benefits and efficacy of methods)

Nutrition ❑
Available Clinic Services ❑
Importance of exams and testing ❑

To the best of my knowledge, the above history is accurate and complete. Educational information has been given to me as indicated above. I have been given the opportunity to ask questions. If I am 18 years old or younger, I have been strongly encouraged to discuss my family planning needs with my parents. If I use tobacco, I have been given information and understand the health risk of using tobacco. I have been told that if tests are taken for sexually transmitted infections (STI's), reporting of positive results to public health agencies is required by law. I understand that the Nebraska Health and Human Services may access my medical record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, and treatment at this clinic.

Patient Signature:_____Staff Signature:_____Date:_____

SEXUAL HEALTH ASSESSMENT

- Please circle your appropriate age group: Under 24 25 – 40 41 or older
- Have you had any of the following:
  - ⇒ New or multiple partners in the last 90 days? Yes No
  - ⇒ Contact with a partner with a sexually transmitted disease? Yes No
  - ⇒ Signs and/or symptoms of a sexually transmitted disease? Yes No

  If yes, check all that apply:
  - _____ Vaginal discharge that you feel is not normal for you
  - _____ Spotting between periods
  - _____ Pain with sexual intercourse
  - _____ Painful periods
  - _____ Urinary burning
- Have you recently had unprotected sex? Yes No
- Do you use condoms? Yes No If yes, how often? _____
- Do you have sex with:
  - ☐ Men
  - ☐ Women
  - ☐ Both men and women
- Do you have:
  - ☐ Vaginal sex
  - ☐ Oral Sex
  - ☐ Anal sex
- Have you ever had an STD? Yes No
- Do you use:
  - ☐ Alcohol
  - ☐ Drugs, other than those prescribed for you
  - ☐ IV Drugs
- Is your partner currently incarcerated or has your partner been released from a correctional facility (jail, prison, etc.) within the last year? Yes No
- Did you have a blood transfusion or were you given other blood products **BEFORE** 1985?

  Yes No

  (DO NOT FILE IN PATIENT MEDICAL RECORD)

CONSENT FOR CONTRACEPTIVE (BIRTH CONTROL) SUPPLIES

Name_____ DOB_____ Date_____

I hereby acknowledge that I am voluntarily requesting the clinician and staff of this clinic to provide contraceptive supplies to me. Benefits, risks, side effects, discontinuation issues and effectiveness of available methods of contraception have been explained to me. I have been told that the most frequent benefits, risks and side effects that I might experience are those listed below, but others not listed may possibly occur, and I should thoroughly read the manufacturers information I receive with the prescription.

Method	Effectiveness	Benefits	Risks	Side Effects	Discontinuation Issues
Oral Contraceptives (pill)	99.6% if taken correctly; 97% progestin only if taken correctly	♦ Less cramping ♦ Less bleeding ♦ Helps regulate cycle ♦ Reduces PMS ♦ Improves acne ♦ Monthly period ♦ Decreases risk of Ovarian & Endometrial Cancer	♦ Increased risk of heart attack and stroke (smoking doubles risk factors) ♦ Blood clots in legs/lungs ♦ Gall bladder disease (especially with long use) ♦ High Blood Pressure ♦ Decreased protection from pregnancy when taken with certain drugs.	♦ Spotting between periods ♦ Headaches ♦ Visual problems ♦ Breast tenderness ♦ Mood changes/ Depression	♦ Pregnancy ♦ Irregular Cycles ♦ Heavy periods ♦ Increased cramping with periods ♦ PMS ♦ ACNE
EVRA (Patch)	99% when used correctly	♦ Convenient ♦ Weekly Regimen ♦ Monthly period ♦ Verifiable ♦ No need for oral administration	♦ Increased risk of heart attack and stroke (smoking doubles risk factors) ♦ Blood clots in legs/lungs ♦ Gall bladder disease (especially with long use) ♦ May not be effective in women more than 198 lbs.	♦ Breast tenderness ♦ Headache ♦ Application site reaction ♦ Nausea	♦ Pregnancy ♦ Irregular Cycles ♦ Heavy Periods ♦ Increased cramping with periods ♦ PMS ♦ ACNE
Implanon (Single rod implant)	99% when used correctly	♦ Can use while breastfeeding ♦ Highly Effective for 3 years ♦ Discreet ♦ Decreases cramps ♦ No Estrogen	♦ Blood clots of the arteries and veins ♦ Patients with liver disease need close monitoring	♦ Menstrual Irregularities ♦ Headache ♦ Breast tenderness ♦ Possible Wt. Gain ♦ Ovarian Cysts	♦ Pregnancy ♦ Irregular Cycles ♦ Change in Period(may become lighter or heavier) ♦ Increased cramping with periods
Depo Provera (150mg/injectable)	99% if injections are every 12 weeks	♦ Convenient ♦ Less bleeding ♦ No Estrogen ♦ Improved Menstrual Symptoms	♦ Possible drug interactions ♦ Long term use contributes to bone loss (longer than 2 years)	♦ Weight gain ♦ Possibly no periods after 6-9 weeks ♦ Headaches ♦ Depression	♦ Pregnancy ♦ Lack of a period for up to 1 year ♦ Increased bleeding with periods ♦ Increased Menstrual Symptoms
Nuva Ring	96% when used correctly	♦ Convenient ♦ Easy to use ♦ Consistent Hormones ♦ Good Cycle Control ♦ Improves acne ♦ Monthly period	♦ Increased risk of heart attack and stroke (smoking doubles risk factors) ♦ Blood clots in legs/lungs ♦ Liver tumors ♦ Rare Cases of Toxic Shock Syndrome	♦ Headache ♦ Increased vaginal discharge ♦ Vaginal irritation or infection ♦ Nausea ♦ Breast tenderness	♦ Pregnancy ♦ Irregular Cycles ♦ Heavy Periods ♦ Increased cramping with periods ♦ PMS ♦ ACNE
Para Guard IUC	99.2%	♦ No hormones ♦ Convenient ♦ Can last up to 10 years	♦ Perforation of uterus ♦ Increased chance of infection in tubes and uterus if infected with STD ♦ Allergy to copper ♦ Increased risk of Ectopic pregnancy, if conception occurs with IUC in place	♦ Increased menstrual bleeding and cramping ♦ Possible anemia due to increased menstrual flow	♦ Pregnancy
Mirena IUC	99.9%	♦ Convenient ♦ Can last up to 5 years ♦ Decreased menstrual flow ♦ Improvement of cramping with menses	♦ Perforation of uterus ♦ Increased chance of infection in tubes and uterus if infected with STD ♦ Increased risk of Ectopic pregnancy, if conception occurs with IUC in place	♦ Mood changes ♦ Acne ♦ Headache ♦ Breast tenderness ♦ Nausea ♦ Changes in menstrual bleeding	♦ Pregnancy ♦ Increased bleeding with periods ♦ Increased cramping with periods
Diaphragm with contraceptive jelly	80 – 95% Depending on use	♦ No hormones ♦ Rare side effects ♦ No risks	♦ None	♦ Rare allergy to rubber ♦ Rare allergic reaction to contraceptive jelly	♦ Pregnancy
Condoms and/or Foam	60 – 96% Depending on use	♦ No prescription needed ♦ STD infection decreased	♦ None	♦ Rare allergy to rubber or foam	♦ Pregnancy ♦ Increased risk for STI's

Method	Effectiveness	Benefits	Risks	Side Effects	Discontinuation Issues
Fertility Awareness Methods Examples to consider: Natural Family Planning; Lactation	75 – 98% Depending on how well instructions were followed and method chosen	♦ Helpful in planning or preventing pregnancy ♦ Increase body awareness ♦ Safe Medically	♦ Unplanned pregnancy	♦ Needs in-depth instructions ♦ Must keep record for several cycles before use ♦ May restrict sexual spontaneity ♦ Women with irregular cycles may have difficulty using this method	♦ Pregnancy

I have had an opportunity to discuss other methods such as abstinence, withdrawal, male and female sterilization. Realizing that no method is 100% effective, I voluntarily request _____ as a method of birth control, and release this clinic, medical staff and employees of any and all liability for any adverse results that my occur. Detailed instructions for use of this method have been provided to me. I understand the benefits and risks of _____ I have had the opportunity to ask questions about my chosen method and this consent form.

I have been told that I may stop using this method at anytime, and am aware that discontinuing could result in pregnancy, but should contact the clinic first for instructions. In order to lessen the chances of serious problems, I have been told that **IT IS MY RESPONSIBILITY TO REPORT TO THIS CLINIC, OR EMERGENCY PROVIDER**, any of the following:

All Methods (except IUC)	A	Abdominal pain
	C	Chest pain
	H	Headaches (severe, sudden onset)
	E	Eye problems (blurred vision, loss of vision)
	S	Severe leg pain, calf or thigh swelling, tenderness

IUC:	P	Period late (pregnancy), abnormal spotting or bleeding
	A	Abdominal pain, pain with intercourse
	I	Infection exposure (STD), abnormal discharge
	N	Not feeling well, fever chills
	S	String missing, shorter or longer

Clinic Phone_____ Emergency Provider_____ Phone_____

Patient Signature_____ Witness_____ Date_____