FAMILY PLANNING ASSESSMENT RECORD

Recipient's Name: _____ Medicaid Number: _____ Age: _____
Date of Service: _____Type of service: Initial Visit _____ Annual Visit _____ Periodic Visit _____

FAMILY HISTORY (Code Member Having Disease: F-Father, M-Mother, S- Sibling, G-Grandparent, O-Other)

Heart disease	_____	Diabetes	_____	Mentally Challenged Retardation	_____	Tuberculosis	_____
Blood disorder	_____						
Stroke	_____	Cancer	_____	Mental Illness	_____	Birth defects	_____
	_____						
Asthma	_____	HTN	_____	Alcohol/drug abuse	_____	Other	_____

MEDICAL/SURGICAL/OB-GYN HISTORY (Code: O=Negative, +=Positive, Detail positive answers)

Diabetes	_____	Epilepsy	_____	Tobacco Use	_____	Mental Illness	_____
Abortions	_____						
Hypertension	_____	Hepatitis	_____	Phlebitis	_____	GYN Surgery	_____
Stillbirths	_____						
Heart Disease	_____	TB	_____	Asthma	_____	Gravida	_____
Medications	_____						
Kidney Disease	_____	Thyroid	_____	Allergies	_____	Para	_____
Other	_____						

MENSTRUAL/CONTRACEPTIVE HISTORY:

Last Menstrual Period: _____
Previous Contraceptive Method: _____
Current Contraceptive Method: _____
Problems with method: _____

LAB SERVICES

Check all applicable boxes:

□ VDRL
□ Urinalysis
□ Pap Smear
□ Hemoglobin/Hematocrit
□ Pregnancy Test
□ Other: _____
□ GC Culture
□ Human Papillomavirus (HPV)
□ Human Immunodeficiency Virus (HIV)

ASSESSMENT

SYSTEM	NORMAL	ABNORMAL	DESCRIBE ABNORMALS
General Appearance			
Skin			
Eyes			
ENT			
Head/Neck/Thyroid			
Nodes			
Heart			
Lungs			
Breasts			
Abdomen			
Extremities			
External Genitalia			
Glands			
Vagina			
Cervix			
Uterus Size/Shape			
Adnexa			
Recto/Vaginal			
Rectum			

CHECK APPLICABLE BOX: At least one box must be checked.

□ Family Planning Counseling Using PT+ 3 Teaching Method

OR

□ Alternative Family Planning Counseling (check all applicable boxes indicating completion):

- □ Reproductive anatomy/physiology _____
- □ Contraceptive methods & effectiveness _____
- □ Side effects/dangers _____
- □ How to use chosen method_____
- □ Contraception Fact sheet given_____
- □ Phone # given for problem/emergency _____

Supplies Given: □ Yes □ No
If yes, indicate type of supplies _____

Prescription Given: □ Yes □ No
If yes, indicate name of prescriptions _____

Next Appointment Date: _____

Signature: _____ Title: _____

Date_____