FAMILY PLANNING AND REPRODUCTIVE HEALTH
BIOLOGICAL FEMALE FLOW SHEET

First Last Middle

Address:

Phone

Patient Number

Date of Birth (MM/DD/YYYY)

1. Date: _____

Reason for visit: _____

Age: _____

2. Allergies (reaction):

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 how it will be handled if necessary. **R**

5. Pregnancy Intention

*Do you want to have (more) children in the next 12 months? □ Yes □ No □ Unsure □I'm ok either way

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

Date of last pregnancy_____

□ 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.

6. *Contraceptive Method at Intake: _____

(see List of methods provided on page 4)

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

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. * Sexual Orientation? □ bisexual □ lesbian, gay or homosexual □ straight or heterosexual □other, something else □unknown
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 an HIV test? ☐ Yes ☐ No If so, when?

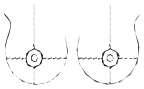
    _____
13. Do you wish to have a HIV test today? ☐ Yes ☐ No

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
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		



IUD strings seen? ☐ Y ☐ N



Comments:

12. Labs:				Comments:
*Cervical Cytology	□ Y	□ N		
*HPV	□ 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	□ Referred for testing	
Other Labs: _____				

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

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

☐ Adolescents must be informed about all methods of contraception **R for adolescents clients**

☐ Use specific methods of contraception and identify adverse effects **(at initiation of a contraceptive method) I**

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

☐ Promote daily consumption of folic acid supplement for those who could become pregnant **I**

☐ Review pregnancy intention **(required annually) I**

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

☐ Provide basic infertility counseling **I**

14. Client-Centered 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**

☐ 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 other services **I**

☐ 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)

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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

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