FAMILY PLANNING AND REPRODUCTIVE HEALTH
BIOLOGICAL FEMALE FLOW SHEET

North Carolina Department of Health and Human Services

Division of Public Health — Reproductive Health Branch

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

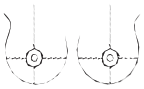
*Indicates item to be extracted to LHD-HSA for Family Planning Annual Report (FPAR)

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		



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: _____				

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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