

FAMILY PLANNING AND REPRODUCTIVE HEALTH BIOLOGICAL MALE FLOW SHEET

First	Last	Middle	6. *Ht: * Wt: BMI: B/P:
Address:			7. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider) 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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. What do you do to protect yourself from STDs and HIV? _____ _____ 6. What ways do you have sex? <input type="checkbox"/> vaginal <input type="checkbox"/> oral <input type="checkbox"/> anal 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 8. Have you ever had an STD? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which STD and when? _____ _____ 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? _____ _____ 10. Have you or any of your partners ever injected drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Have you or any of your partners exchanged money or drugs for sex? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Have you had a HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____ 13. Do you wish to have a HIV test today? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone			
Patient Number			
Date of Birth	(MM/DD/YYYY)		
1. Date: _____ Reason for visit: _____ Age: _____			
2. Allergies (reaction):			
3. 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? _____ <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			
4. 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)? _____			
5. *Contraceptive Method at Intake: <i>(see List of methods provided on page 4)</i> *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"/> Partner Seeking Pregnancy 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 Do you have any problems/concerns about male or female methods? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain:			

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

DHHS 2814M (Reviewed 06/2025)

Reproductive Health Branch (Review 06/2028)

8. 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

9. 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		
Rectal bleeding		
Urinary frequency, urgency, burning/blood in urine		
Easy bruising or bleeding		
Rashes/growths/lesions		
Other problems		

10. Physical Exam:	Code	Comments
Skin		
HEENT		
Neck/Thyroid		
Lungs		
Heart		
Abdomen		
Extremities		
Prostate		
Penis		
Testicles		
Rectum		



Comments:

11. Labs:	Comments:
*GC <input type="checkbox"/> Y <input type="checkbox"/> N	
Urethral smear <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	
*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 <input type="checkbox"/> Y <input type="checkbox"/> N	

<p>12. Education/Counseling: Information needed to make informed decisions regarding family planning: (check all that apply)</p> <p><input type="checkbox"/> Adolescents must be informed about all methods of contraception R for adolescent clients</p> <p><input type="checkbox"/> Use specific methods of contraception and identify adverse effects (at initiation of a contraceptive method) I</p> <p><input type="checkbox"/> Reduce risk of transmission of STDs and HIV based on sexual risk assessment I</p> <p><input type="checkbox"/> Review pregnancy intention (required annually) I</p> <p><input type="checkbox"/> Review immunization history and inform client of recommended vaccine per CDC's ACIP Guidelines and offer, as indicated, or refer to other providers R</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/> Understand BMI greater than 30 or less than 18.5 is a health risk (weight management educational materials to be provided to clients if client requests) I</p> <p><input type="checkbox"/> Stop tobacco or Electronic Nicotine Delivery System (ENDS) use, implementing the 5A counseling approach I</p> <p><input type="checkbox"/> * Provide counseling to become pregnant and preconception counseling I</p> <p><input type="checkbox"/> Provide basic infertility counseling I</p>	<p>13. Client-Centered Method Counseling: Individual dialogue covers:</p> <p><input type="checkbox"/> Results of physical assessment and labs (if performed) R</p> <p><input type="checkbox"/> * Client centered contraceptive counseling/education provided R</p> <p><input type="checkbox"/> Provide Emergency Contraception Counseling if pregnancy is not desired I</p> <p><input type="checkbox"/> Protection from STDs if non-barrier method is chosen I</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> When to return for a follow up (planned return schedule) R</p> <p><input type="checkbox"/> Appropriate referral for other services I</p> <p><input type="checkbox"/> Teach Back Method used <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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14. Assessment/Plan/Method/Referrals:

*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 ☐ Partner Seeking Pregnancy

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

Nurse Interviewer: _____

Nurse Dispensing if Different from Interviewer: _____

Examiner Signature: _____

15. (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