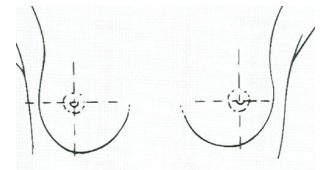


Family Planning Female Visit:

SUBJECTIVE Reason for visit/chief complaint	Medications: Allergies:	DES exposure Yes No Date of Exposure:
Review of history Yes No Immunizations reviewed Yes No	LMP: Current contraceptive method:	Last IC

OBJECTIVE DATABASE				X If Normal	NA – not assessed
BP	HT	WT	BMI	NOTES	
ENT					
Thyroid					
Skin					
Breasts					
Heart					
Lungs					
Abdomen					
External Genitalia					
Vagina					
Cervix					
Uterus					
Adnexa					
Rectum					
Lymphatic					
Extremities					
Other Findings					



Laboratory	X if Done	Pt declined	Results	Notes
Gonorrhea/Chlamydia				U R V P C
Pregnancy Test				
Pap Smear				
HPV				
HIV Screen				
Syphilis				
Hepatitis (specify)				
Wet Mount				
Urine Analysis				
Other Lab (Specify)				
Counseling/Education				
STD/HIV				
Reproductive Life Plan				
Preconception Health				
Contraceptive Plan				
Method information				
Sexuality/Relationships				
IPV/DV				
Condoms				
Infertility				
Pregnancy counseling (per protocol)				
Prenatal Care				
Adolescent Counseling (family participation, sexual coercion, mandatory reporting and abstinence)				
Victim Assessment				
Referrals (if indicated) specify				

ASSESSMENT:

PLAN:

Patient understanding confirmed Yes No	Mandatory Reporting (if applicable) Yes	Reported to: DFS	Law Enforcement WHC Other
Name (Print)	Age	Date of Birth	Client Number
Signature (Clinician)			Date