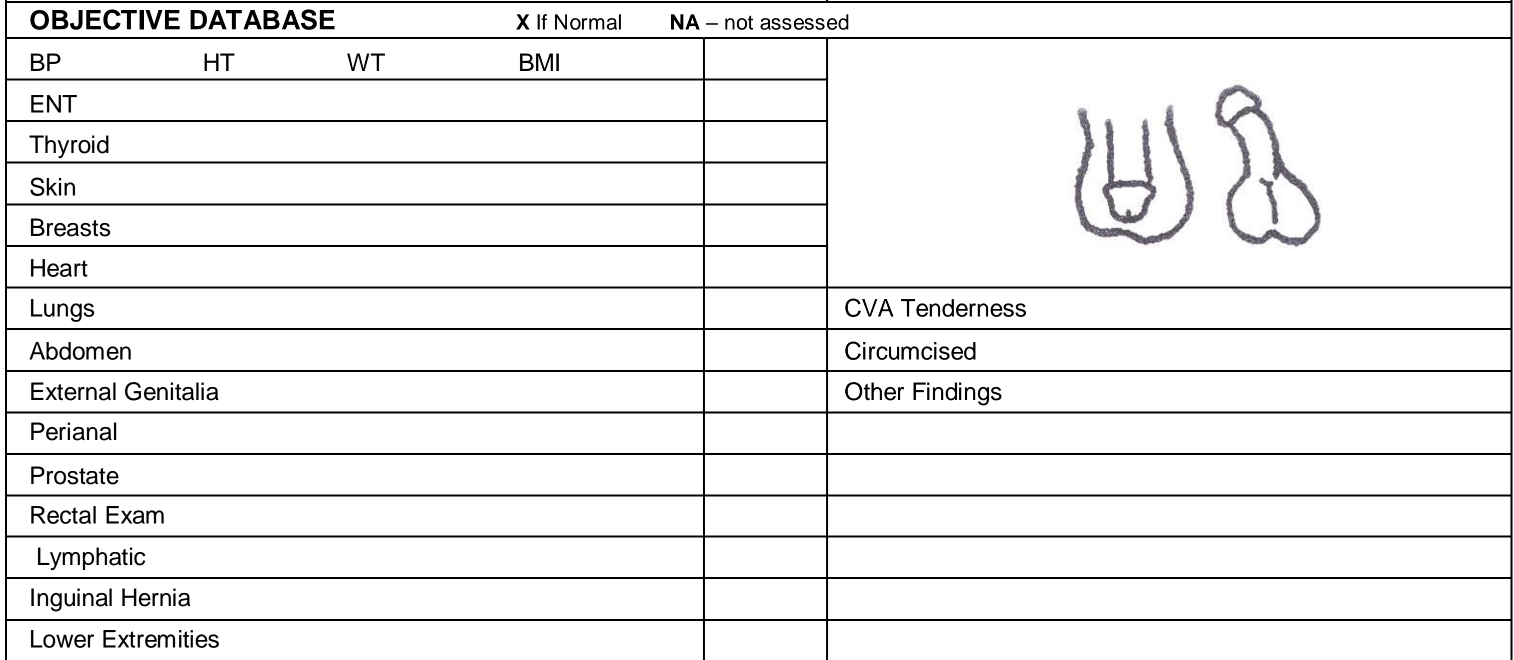
Family Planning Male Visit:

SUBJECTIVE Reason for Visit/Chief Complaint	Medications: Allergies:
Review of history Yes No Immunizations reviewed Yes No	Last IC: Current contraceptive method:

OBJECTIVE DATABASE **X** If Normal **NA** – not assessed



BP HT WT BMI		
ENT		
Thyroid		
Skin		
Breasts		
Heart		
Lungs		CVA Tenderness
Abdomen		Circumcised
External Genitalia		Other Findings
Perianal		
Prostate		
Rectal Exam		
Lymphatic		
Inguinal Hernia		
Lower Extremities		

Laboratory	**X if Done**	**Pt declined**	**Results**	**Counseling/Education**	**X if Done**	**Notes**
HIV Screen				STD/HIV		
Gonorrhea/Chlamydia U P R				Reproductive Life Plan		
Syphilis				Condoms		
Hepatitis (Specify)				Contraception Plan		
Urine Analysis				Sexuality/Relationships		
Other Lab (Specify)				IPV/DV		
				Preconception Health		
				Sexual Disfunction		
				Infertility		
				Substance Use		
				Tobacco Cessation		
				Adolescent Counseling		
				Victim Assessment		

Referral (if indicated) specify

ASSESSMENT:

PLAN:

<table>
<tr><td>Patient understanding confirmed
Yes No</td><td colspan="4">Mandatory Reporting (if applicable) Yes Reported to: DFS Law Enforcement WHC Other</td></tr>
<tr><td colspan="2">Name (Print)</td><td>Age</td><td>Date of Birth</td><td>Client Number</td></tr>
<tr><td colspan="4">Signature (Clinician)</td><td>Date</td></tr>
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