North Carolina Department of Health and Human Services Division of Public Health — Reproductive Health Branch

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| First Last Middle | | **6.** **Ht: Wt: BMI: B/P:** |
| **7.** **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?     1. In the past 12 months, how many partners have you had sex with?      1. 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 2. What do you do to protect yourself from STDs and HIV?      1. 6. What ways do you have sex? □ vaginal □ oral □ anal 2. 7. Do you or your partner use condoms and/or dental dams every  time you have vaginal, oral or anal sex? □ Yes □ No 3. 8. Have you ever had an STD? □ Yes □ 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)   □ 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 a HIV test? □ Yes □ No If so, when?  13. Do you wish to have a HIV test today? □ Yes □ No |
| Address: | |
| Phone | |
| Patient Number | |
| Date of Birth | (MM/DD/YYYY) |
| 1. Date:   Reason for visit:  Age: | |
| **2.** **Allergies (reaction):** | |
| **3.** **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 ho w it will be   handled if necessary. R  □ Adolescents should be provided intervention to prevent  initiation of tobacco use. R | |
| **4.** **Reproductive Life Planning (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)? | |
| **5. \***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 □Partner Seeking Pregnancy  Satisfied? □ Yes □ No   Desired method changed? □ Yes □ No  **Unprotected Intercourse in Past Five Days:** □ Yes □ No    **Do you have any problems/concerns about male or female   methods?** □ Yes □ No **if yes, please explain:** | |

**FAMILY PLANNING AND REPRODUCTIVE HEALTH BIOLOGICAL MALE FLOW SHEET**

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| 1. **MENTAL HEALTH HISTORY** 2. 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   1. Are you in a relationship with a person who threatens or physically hurts you? □ Yes □ No 2. 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 |  |  | | Prostrate |  |  | | Penis |  |  | | Testicles |  |  | | Rectum |  |  |  |  | | --- | | **Comments:** | |

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| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **11. Labs:** | | | | | **Comments:** | | | \*GC | □ Y □ N | | | |  |  | | Urethral smear | □ Y □ N | | | |  |  | | \*Chlamydia | □ Y □ N | | | |  |  | | \*HIV | □ Y □ N | | | |  |  | | \*Syphilis | □ Y □ N | | | |  |  | | Glucose | □ Y □ N | | | |  |  | | Hepatitis C | □ Y □ N □ Referred for testing | | | |  |  | | Other labs | □ Y □ N | | | |  |  | |  | |  |  |  |  |  | |

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| **12. Education/Counseling: Information needed to make informed decisions regarding family planning: (check all that apply)**    □ Use specific methods of contraception and identify adverse effects  (at initiation of a contraceptive method) **R**  □ Reduce risk of transmission of STDs and HIV based on sexual risk  assessment **I**  □ Provide reproductive life planning counseling **R**  □ Review immunization history and inform client of recommended  vaccine per CDC’s ACIP Guidelines and offer, as indicated, or  refer to other providers **R**  □ Provide preconception counseling **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 client requests) **I**  □ Stop tobacco or Electronic Nicotine Delivery System (ENDS) use,  implementing the 5A counseling approach **I**  □ \*Provide achieving pregnancy counseling **I**  □ Provide basic infertility counseling **I** | **13.** **Client Method Counseling: Individual dialogue covers:**  □ Results of physical assessment and labs (if performed) **R**  □ \*Client centered contraceptive counseling/education  provided **R**  □ Provide Emergency Contraception Counseling if  pregnancy is not desired **I**  □ Adolescents must be counseled on abstinence, condoms  LARC, and other methods of birth control **R**  □ How to discontinue the method selected and information  on back up method used **R**  □ Typical use rates for method effectiveness **R**  □ How to use the method consistently and correctly **R**  □ 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 additional services as needed **R**  □ Teach Back Method used □ Yes □ No |

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| 1. **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:   1. (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