Planned Parenthood Association of the Mercer Area

Patient Registration Form
Regestación Para Paciente

Patient#/# del paciente_____

Please complete the following form. All the information is confidential.
Por favor complete la hoja seguida. Toda la información es confidencial.

First Name
Primer Nombre _____ Last Name
Apellido _____

Address
Dirección _____ County
Condado _____

City State Zip
Ciudad _____ Estado _____ Código Postal _____

SS# Date of Birth
de Seguro Social _____-____-_____ Fecha de Nacimiento _____/_____/_____

House Hold Income Yearly Monthly Weekly
Ingreso de la casa $_____.____ ❑ Anual ❑ Mensual ❑ Semanal

Family Size How many are children(s)
Cuantos son en tu Familia _____ Cuantos son niño(s) _____

Home phone Work phone
Numero de teléfono (____)____-_____ Numero del trabajo (____)____-_____

Emergency contact Phone number Emergency contact Name
Numero de contacto de emergencia (____)____-_____ Nombre del contacto de emergencia _____

Please check one of the four ways you want to receive you mail from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir corresponda de nosotros (PPAMA)

Full return address ❑ Dirección completa dé retorno
Street address ONLY ❑ Solamente la dirección de la calle
NO return address ❑ SIN dirección
NO mail ❑ Ninguna respeta

Please check one of the four ways you want to receive phone calls from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir llamas de nosotros (PPAMA)

Saying Planned Parenthood ❑ Diciendo Planned Parenthood
Saying Doctor's Office ❑ Diciendo oficina de doctor
Saying it's a friend ❑ Diciendo que es una amiga
NO calls ❑ Ninguna llamadas

Please check all that apply
Por favor marque todo que aplica

Sex Female Male
Sexo - ❑ Femenino ❑ Masculino

Race American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander White
Raza - ❑ Indio Americano o Nativo de Alaska ❑ Asiático ❑ Moreno o Americano Africano ❑ Nativo Hawaiano o Isleño Pacifico ❑ Blanco

Hispanic Yes – Hispanic or Latin Not – Hispanic nor Latin Unknown
Hispano - ❑ Si – Hispano o Latino ❑ No – Hispano o Latino ❑ No sabes

Marital Status Divorced Living together Married Separated Single Widowed
Estado Marital - ❑ Divorciada ❑ Viven juntos ❑ Casada ❑ Separada ❑ Soltera ❑ Viuda

Referral Family o Friend Hospital Hot Line Media Other patient Phone book
Referido - ❑ Familia o Amiga ❑ Hospital ❑ Línea Abierta ❑ Medio de comunicación ❑ Otra paciente ❑ Libro de teléfono
Outreach Private Doctor Welfare
❑ Alcance ❑ Médico privado ❑ Welfare

Language English Other Interpreter Needed
Idioma - ❑ Ingles ❑ Otro _____ ❑ Necesito un Interprete

Student Yes No Highest grade f school you completed
Estudiante - ❑ Si ❑ No Grado mas alto que ha completado en la escuela _____

Planned Parenthood of the Mercer Area

Patient Label

Initial Medical History

Welcome to Planned Parenthood® of the Mercer Area.. These questions will help us assess your health needs. This is a confidential record of your health history.

CONTRACEPTIVE HISTORY

Yes No

☐ ☐ When you have intercourse, do you use a condoms?

☐ ☐ Have you and your partner used any other type of birth control? If so, what_____

PAST/PRESENT MEDICAL HISTORY

1. General

YES NO PLEASE CHECK OFF BELOW

☐ ☐ My health is generally good

☐ ☐ Recent weight gain or loss

☐ ☐ Any cancer, genetic, or hereditary conditions

☐ ☐ Hepatitis A, B, C /Mononucleosis

☐ ☐ Immunizations up to date (Measles, Mumps, Rubella, Hepatitis)

2. Cardiovascular

☐ ☐ Mitral Valve Prolapse

☐ ☐ Heart Murmur/Heart palpitations

☐ ☐ Blood Clots

3. Neurologic

☐ ☐ Diagnosed Migraines

☐ ☐ Persistent numbness, tingling of arms or legs

☐ ☐ Seizure disorder/Epilepsy

4. Musculoskeletal

☐ ☐ Arthritis

5. Eyes

☐ ☐ Eye disorders

☐ ☐ Do you wear glasses or contact lenses

6. Gastrointestinal

☐ ☐ Gallbladder disease or liver disease

7. Respiratory

YES NO

☐ ☐ Breathing problems/Asthma

☐ ☐ Tuberculosis

8. Hematologic

☐ ☐ Anemia/ low iron

☐ ☐ Sickle cell anemia /trait/ thalassemia

☐ ☐ Blood clotting disorder/Leukemia

☐ ☐ Ever have a blood transfusion, what year?____

9. Endocrine

☐ ☐ Thyroid disease

☐ ☐ Diabetes/Diabetes

10. Ears, Nose, Throat, Mouth

☐ ☐ Hearing problems

☐ ☐ Frequent nosebleeds

☐ ☐ Gum disease/chronic strep throat infections

11. Psychological

☐ ☐ Under the care of a pyschiatrist or therapist

☐ ☐ History of depression/anxiety disorder/frequent mood swings

Planned Parenthood of the Mercer Area

Patient Label

FAMILY HISTORY

Indicate which people in your family have had any of the following diseases
(F) father, (M) mother, (B) brother, (S) sister

DOES ANY ONE IN THE FAMILY HAVE ANY OF THE FOLLOWING DISEASES: NO_____ YES_____if yes, please check below

_____ Blood clot(s)
_____ Diabetes
_____ High Blood Pressure
_____ Stroke, Heart Attack, Heart Disease (age of onset: _____)
_____ Breast, Prostate, or Testicular Cancer (age of onset: _____)
_____ Other Cancer _____

SOCIAL HISTORY

YES	NO	
☐	☐	Do you smoke? If so, how many cigarettes per day? _____
☐	☐	Do you drink alcohol? If so, how often/how much? _____
☐	☐	Do you or your partner use street or IV drugs? If so, what? _____
☐	☐	Would you like to receive information on where to get help for a drug or alcohol problem?
☐	☐	Do you want to discuss problems related to rape, incest or domestic violence?
☐	☐	Do you exercise regularly?

SEXUAL HISTORY

These questions may seem personal but they help us to evaluate your health. All information is confidential. Please answer only the questions you are comfortable answering.

YES	NO	
☐	☐	Have you had sexual intercourse? Age first time _____
☐	☐	Are you currently in a sexual relationship? Is your sexual contact: √ all that apply ☐ Vaginal ☐ Anal ☐ Oral ☐ Other
☐	☐	Have you had more than one partner in the past year? _____ Are your partner(s) ☐ Male ☐ Female ☐ Both
☐	☐	Do you practice safe sex? Consistent condom use?
☐	☐	Do you want to be tested for sexually transmitted infections and/or HIV?
☐	☐	Have you ever impregnated a woman? Number of pregnancies___ Number of children__

Do you have any questions or concerns about sex that you would like to discuss today? _____

To the best of my knowledge, the information on this history form is complete and correct.

Patient signature_____ **Date** _____

Sign at initial medical visit and annual update

(REMEMBER--a new medical history form needs to be completed every 3 years by client)

Physician Signature_____ **Date**_____