

**GREEN HILLS COMMUNITY ACTION AGENCY
FAMILY PLANNING**

(Please print, use black ink)

Name: _____
(First) (Last) (Maiden)

Address _____
(Street/PO/RR) (City) (State/ZIP)

May we contact you at the above address? Yes or NO
Please check all the ways we may contact you:

	Number	Time
<input type="checkbox"/> Call Home	_____	_____
<input type="checkbox"/> Call Work	_____	_____
<input type="checkbox"/> Mail/plain env.	_____	_____
<input type="checkbox"/> Cell phone	_____	_____
<input type="checkbox"/> E-mail	_____	_____

Emergency contact person: (name, relationship, phone & address)

Race: (check all that apply)
White Black Asian American Indian/Alaskan
Native Hawaiian/other Pacific Islander Unknown

Hispanic/Latino/Descent (circle one) Yes or No
Do you require a translator? (circle one): Yes or No

Have you received services at this clinic before? Yes or No
I am here today because _____

YOUR PRIVATE

DOCTOR(S)/CLINIC _____ CITY/STATE _____

MEDICAL CARE IN PAST YEAR _____

MEDICATIONS USED IN PAST YEAR _____

DO YOU HAVE A HISTORY OF:

GERMAN MEASLES (RUBELLA) YES NO VACCINATED UNKNOWN
 MONO CANCER STROKE DIABETES GENETIC PROBLEMS
 THYROID DISEASE RHEUMATIC FEVER OBESITY SICKLE CELL
 JAUNDICE/HEPATITIS OTHER _____

HOSPITALIZATIONS/SURGERY-TYPE/DATES _____

MAJOR ILLNESSES/INJURIES-TYPE/DATES _____

ALLERGIES (INCLUDING METALS AND DRUGS) _____

DID YOUR MOTHER TAKE DES (HORMONE) WHILE PREGNANT WITH YOU?

YES NO UNKNOWN

Today's Date _____
SS# _____
County of Residence _____
Date of Birth _____
Age _____
Marital Status _____
Highest grade completed _____
Currently a student: Yes or No

Do you have Medicaid? Yes or No
Medicaid # _____
Do you have Medicaid that covers family planning only and no other health services? Yes or No
Do you have Private Insurance? Yes or No
If yes, please give card to staff for copy.
Does your Private Insurance cover (check one)
Covers all or some FP services _____
Does not cover any FP services _____
Unknown FP coverage _____

Source of Income _____
Are you employed? Yes or No
Monthly household income _____
Place of Employment _____
Number of persons in household _____

ON A TYPICAL DAY:

HOW MANY CIGARETTES DO YOU SMOKE? _____

HOW MANY CUPS OF COFFEE/TEA/POP DO YOU DRINK? _____

IN A TYPICAL WEEK HOW OFTEN DO YOU:

EXERCISE _____

USE ALCOHOL _____

USE STREET DRUGS _____

HAVE YOUR BIRTH PARENTS, GRANDPARENTS, BROTHERS OR SISTERS EVER HAD ANY OF THE FOLLOWING?

(IF ADOPTED, PLEASE DISREGARD)

	YES	NO	?	STAFF COMMENTS
1. DEATH FROM HEART ATTACK BEFORE AGE 50				
2. HIGH BLOOD PRESSURE				
3. PROSTATE CANCER				
4. DIABETES				
5. HIGH BLOOD FAT LEVELS (I.E. CHOLESEROL)				
6. GENETIC PROBLEMS				

ASSURANCE OF CONFIDENTIALITY: THIS MEDICAL RECORD IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR CONSENT EXCEPT AS MAY BE REQUIRED BY LAW.

	DO YOU NOW HAVE, OR HAVE YOU EVER HAD:	YES	NO	?	STAFF COMMENTS
7.	DRUG ABUSE				
8.	IV DRUG USE-ABUSE NOT HOSPITALIZATION				
9.	FREQUENT OR SEVERE HEADACHES				
10.	SEIZURES/FAINTING/NEUROLOGIC DISORGRERS				
11.	EMOTIONAL PROBLEMS/DEPRESSION				
12.	VISION PROBLEMS				
13.	CHEST PAIN/DIFFICULT BREATHING				
14.	HEART PROBLEMS/MURMURS				
15.	HIGH BLOOD FAT LEVELS (I.E. CHOLESTEROL)				
16.	HIGH BLOOD PRESSURE				
17.	BLOOD CLOTS IN VEINS/VARICOSE VEINS				
18.	ANEMIA/BLOOD DISORDERS				
19.	BREAST DISEASE/LUMP/NIPPLE DISCHARGE				
20.	STOMACH/INTESTINAL PROBLEMS				
21.	GALL BLADDER OR LIVER DISEASE PROBLEMS				
22.	KIDNEY/BLADDER PROBLEMS/INFECTIONS				
23.	PAIN/BURNING OR FREQUENT URINATION				
24.	UNUSUAL PENIS DISCHARGE				
25.	FEVER OR CHILLS				
26.	LOWER ABDOMINAL PAIN OR PRESSURE				
27.	PAIN/BLEEDING WITH INTERCOURSE				
28.	GONORRHEA, SYPHILIS, CHLAMYDIA, HERPES, WARTS				
29.	ARE YOU CURRENTLY SEXUALLY ACTIVE? HAVING MORE THAN ONE SEX PARTNER INCREASES THE CHANCE OF SEXUAL TRANSMITTED DISEASES, (STD)				
30.	HAVE YOU HAD MORE THAN ONE SEX PARTNER IN THE PAST YEAR? LIFETIME _____				
31.	DOES YOUR PARTNER(S) HAVE STD SYMPTOMS?				
32.	KNOWN OR SUSPECTED HOMOSEXUALITY/BISEXUALITY IN YOUR PARTNER: PAST _____ PRESENT _____				
33.	YOUR AGE AT TIME OF FIRST INTERCOURSE _____				
34.	PAINFUL INTERCOURSE				
35.	TYPE OF INTERCOURSE: ANAL ___ ORAL ___ VAGINAL ___				
36.	ARE YOU CURRENTLY USING BIRTH CONTROL?				
37.	IF YES, WHICH METHOD? CONDOM WITHDRAWAL SELF STERILE PARTNER STERILE				
38.	PROBLEMS WITH ANY OF THESE METHODS?				
39.	WHAT METHOD DO YOU WANT NOW? _____				
40.	DO YOU PLAN TO HAVE CHILDREN IN THE FUTURE?				