State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

Governor

May 31, 2007

TO: FAMILY PACT (PLANNING, ACCESS, CARE, AND TREATMENT) PROVIDERS

SUBJECT: FAMILY PACT PROGRAM LETTER 07-04:
1) ANNOUNCING "MEDICAL HISTORY AND EXAM FORMS"
2) *CLINICAL PRACTICE ALERT*: "PROVIDING CLINICAL SERVICES TO FEMALE ADOLESCENTS"

The California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch announces the release of two new clinical resources for Family PACT providers.

Family PACT Medical History and Medical Exam Forms

The Medical History and Medical Exam forms were developed by experts in the fields of family planning and sexually transmitted infections to assist providers in obtaining and documenting clinically relevant reproductive health histories and risk assessments for their Family PACT clients. These forms were developed in response to requests by providers and contain relevant data elements thought to be essential for the provision of Family PACT services. The use of these forms is optional.

The Medical History forms are gender specific and are currently available in English and Spanish. These are intended to be self-administered; however, clients with limited literacy skills may require assistance. The Medical Exam forms are also gender specific and include questions regarding risks to reproductive health that should be considered at each visit.

Family PACT Standards, defined in the *Policies, Procedures, and Billing Instructions* (PPBI) manual, require that a comprehensive health history with updates every 24 months be maintained for each client. The history should include: health risk factors; a

Maternal Child Adolescent Health/Office of Family Planning Branch, Primary Care and Family Health Division
1615 Capitol Avenue, P.O. Box 997413, MS 8400, Sacramento, CA 95899-7413
(916) 650-0414
Internet Address: http://www.dhs.ca.gov/ofp

complete family history; a personal medical, sexual, and contraceptive history; plans for having children; and an obstetrical and gynecological history for women.

For your convenience, these forms can be downloaded from the Family PACT Web site at www.familypact.org, on the “Provider Resource” page, located under the “Providers” menu. The content of these tools may be modified or adapted to meet the needs of your practice, without prior approval by MCAH/OFP.

***Clinical Practice Alert*: “Providing Clinical Services to Female Adolescents”**

The enclosed *Clinical Practice Alert* has been developed to highlight the ways in which the program serves the unique needs of adolescent females. A recent Family PACT Webcast featured Erica Monasterio, M.N., F.N.P., discussing “Meeting the Needs of Adolescents and Males.” The slideshow/audio of this presentation may be accessed on the Family PACT Web site under Provider Training.

If you are interested in bringing more teens into your practice and wish to collaborate with a community-based organization in your area, please see the listing of Teen Pregnancy Prevention Programs partner organizations on the Family PACT Web site under Provider Resources.

Clinical Practice Alerts provide an interpretation of the Family PACT Program Standards. Please share this document with all clinicians providing services to Family PACT clients.

If you have questions or comments about the Medical History and Medical Exam forms or the *Clinical Practice Alert*, you may contact John Mikanda, M.D., M.P.H., Chief of MCAH/OFP’s Clinical Services and Quality Improvement Utilization Section at (916) 650-0414 or email fampact@dhs.ca.gov.

Sincerely,

Laurie Weaver, Chief
Office of Family Planning

Enclosures

Name **Age** **Date of Birth** **Date**

FEMALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

❑ Yes ❑ No Are you allergic to any medications? List here:

❑ Yes ❑ No Do you take any over the counter medicines, prescription medicines, vitamins, supplements or home remedies? List here:

❑ Yes ❑ No Do you have a usual source of primary care? If yes, who?

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

1. ❑ Heart attack/disease
2. ❑ Stroke
3. ❑ Blood clots in legs/lungs
4. ❑ High blood pressure
5. ❑ High cholesterol
6. ❑ Diabetes
7. ❑ Alcohol or drug abuse
8. ❑ Birth defects/Genetic problems
9. ❑ Mental illness
10. ❑ Maternal DES exposure
11. ❑ Cancer
12. ❑ I do not know my family medical history

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ❑ Heart disease
B. ❑ High blood pressure
C. ❑ Stroke
D. ❑ Diabetes
E. ❑ High cholesterol
F. ❑ Tuberculosis (TB)
G. ❑ Asthma
H. ❑ Blood clot in leg/lungs
I. ❑ Bleed/bruise easily
J. ❑ Anemia
K. ❑ Sickle cell disease
L. ❑ Kidney/bladder problems
M. ❑ Seizures or epilepsy
N. ❑ Depression
O. ❑ Suicidal thoughts
P. ❑ Mental illness
Q. ❑ Severe headaches or migraines
R. ❑ Liver problems/ Hepatitis
S. ❑ Gall bladder disease
T. ❑ Eating disorder
U. ❑ Cancer Type: ____________
V. ❑ Thyroid disease
W. ❑ Fibroids
X. ❑ Ovarian cyst/abnormality
Y. ❑ Endometriosis
Z. ❑ Infertility

2. ❑ Yes ❑ No Have you ever been hospitalized or had any surgery? If yes, when and why? ____________
3. ❑ Yes ❑ No Have you ever had a transfusion or blood exposure?
4. ❑ Yes ❑ No Have you been immunized against rubella? ❑ Don't know
5. ❑ Yes ❑ No Have you been immunized against Hepatitis B? ❑ Don't know
6. When was your last Pap smear? ____________ ❑ Never had a Pap smear
   ❑ Yes ❑ No Have you ever had an abnormal Pap smear? If Yes, when? ____________
7. ❑ Yes ❑ No Have you ever had an HIV test? If yes, when was your last one? ____________ Was it ❑ Positive ❑ Negative?
8. ❑ Yes ❑ No Have you ever had a mammogram? If yes, when was your last one? ____________ Was it normal? ____________

C. Menstrual History:

1. Age period started: ____________
2. Periods come every ____________ days and last ____________ days.
3. Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Light ❑ Moderate ❑ Heavy
4. ❑ Yes ❑ No Do you have bleeding or spotting in between your periods?

D. Pregnancy History: If you have never been pregnant, skip to next section.

1. Please list the number of the following: _____ Pregnancies
   _____ Live births _____ Miscarriages _____ Abortions _____ Ectopic (tubal) pregnancies
2. How long ago was your last pregnancy? ____________ month/year(s)
3. ❑ Yes ❑ No Are you breast feeding currently?

Provider notes:

www.familypact.org

Name **Age** **Date of Birth** **Date**

E. Contraception History:

1. How old were you when you first had vaginal intercourse? ______ years old ❏ Never had sex
2. How important is it for you to avoid pregnancy now? ❏ Very ❏ Somewhat ❏ Not at all
3. What birth control methods have you used in the past? ❏ None
   - A. ❏ Condoms/rubbers
   - B. ❏ Birth control pills
   - C. ❏ DepoProvera/Shot
   - D. ❏ Patch
   - E. ❏ NuvaRing (vaginal ring)
   - F. ❏ IUD
   - G. ❏ Implants under the skin
   - H. ❏ Diaphragm/cervical cap
   - I. ❏ Tubal ligation/tubes tied
   - J. ❏ Foam/Film or Jelly
   - K. ❏ Withdrawal/pulling out
   - L. ❏ Rhythm method
   - M. ❏ Partner has vasectomy
4. What birth control are you and your partner(s) currently using?________________❏ None
5. ❏ Yes ❏ No Are you happy with your method?
6. How often do you use condoms? ❏ Always ❏ Sometimes ❏ Never
7. ❏ Yes ❏ No Have you ever used emergency contraception (morning after pill/Plan B)?
8. ❏ Yes ❏ No ❏ Maybe Are you planning to get pregnant in the next two years?

F. Habits and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week?____________ ❏ None
2. ❏ Yes ❏ No Do you smoke cigarettes? If yes, how many cigarettes per day?____________
3. ❏ Yes ❏ No Do you use any street drugs? If yes, please list:____________________
4. ❏ Yes ❏ No Have you ever used injected drugs?
5. ❏ Yes ❏ No Have you ever shared needles?
6. ❏ Yes ❏ No Has anyone ever told you that you have a problem with drugs or alcohol?
7. ❏ Yes ❏ No Is anyone, including your partner, threatening you, causing you to be afraid or hurting you physically?
8. ❏ Yes ❏ No Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of: ❏ Drug use ❏ Sex with men ❏ HIV

G. Sexual History

In the last 12 months...

1. ❏ Yes ❏ No Have you been sexually active?
   If yes, how many sexual partners have you had?____________
2. Have you had sex with ❏ Men ❏ Women ❏ Both?
3. Have you and/or your partner(s) had ❏ Oral sex ❏ Anal sex ❏ Vaginal sex?
4. ❏ Yes ❏ No Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   ❏ Yes, definitely ❏ Not sure, possibly ❏ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
   - A. ❏ Chlamydia
   - B. ❏ Gonorrhea
   - C. ❏ Genital Herpes
   - D. ❏ Trichomoniasis (Trich)
   - E. ❏ Pelvic Inflammatory Disease
   - F. ❏ Genital Warts
   - G. ❏ Bacterial Vaginosis (BV)
   - H. ❏ Syphilis
   - I. ❏ Other:____________
7. ❏ Yes ❏ No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?______________________________

____

____

Patient Signature/Date

____

Clinician Signature/Date

Provider notes:

www.familypact.org

Nombre **Edad** **Fecha de Nacimiento** **Fecha**

HISTORIA MÉDICA PARA MUJERES

Esta información es confidencial y será utilizada por su proveedor médico para asegurar que usted obtenga el cuidado apropiado.

❏ Sí ❏ No ¿Es usted alérgica a medicamentos? Si contestó sí, listelos aqui:

❏ Sí ❏ No ¿Usted toma medicamentos, suplementos, vitaminas, o remedios caseros? Si contestó sí, listelos aqui:

❏ Sí ❏ No ¿Tiene un doctor que la atiende normalmente? Si contestó sí, quién es?

A. Historia Médica Familiar:

¿Ha tenido alguien en su familia problemas con lo siguiente? (madre, padre, abuelos, hermanos):

1. ❏ Enfermedad del corazón
2. ❏ Derrame cerebral
3. ❏ Coágulos de sangre en las piernas o pulmones
4. ❏ Alta presión
5. ❏ Colesterol alto
6. ❏ Diabetes
7. ❏ Problemas con alcohol o drogas
8. ❏ Defectos de nacimiento
9. ❏ Problemas psiquiátricos
10. ❏ Cáncer
11. ❏ Expuesta a DES
12. ❏ No conozco mi historia médica familiar

B. Historia Médica Familiar:

1. ¿Ha tenido USTED problemas con lo siguiente? Marque todo que aplique.

A. ❏ Enfermedad del corazón
B. ❏ Alta presión
C. ❏ Derrame cerebral
D. ❏ Diabetes
E. ❏ Colesterol alto
F. ❏ Tuberculosis (TB)
G. ❏ Asma
H. ❏ Coágulos de sangre en las piernas o pulmones
I. ❏ Hemorragias/coagulación
J. ❏ Anemia
K. ❏ Anemia drepanocítica
L. ❏ Infertilidad
M. ❏ Problemas del riñón/vejiga
N. ❏ Convulsiones o epilepsia
O. ❏ Depresión
P. ❏ Pensamientos suicidas
Q. ❏ Problemas psiquiátricos
R. ❏ Dolores de cabeza severos o migraña
S. ❏ Problema del higado/ Hepatitis
T. ❏ Enfermedad de la vesícula biliar
U. ❏ Desórdenes alimenticios
V. ❏ Cáncer, Típo:________
W. ❏ Tiroides
X. ❏ Fibroma
Y. ❏ Quistes en los ovarios
Z. ❏ Endometriosis

2. ❏ Sí ❏ No ¿Ha estado hospitalizada o ha tenido cirugía? Si contesto sí, ¿cuándo y por qué?________
3. ❏ Sí ❏ No ¿Ha tenido una transfusión o contacto con sangre?
4. ❏ Sí ❏ No ¿Ha sido inmunizada contra rubella? ❏ No sé
5. ❏ Sí ❏ No ¿Ha sido inmunizada contra Hepatitis B? ❏ No sé
6. ¿Cuándo fue su última Papanicolau?________ ❏ Nunca he tenido un Pap
   ❏ Sí ❏ No Ha salido jamás anormal su prueba Papanicolau? Si contestó sí, cuándo fue? ________
7. ❏ Sí ❏ No ¿Ha tenido jamás usted una prueba de VIH? Si contestó sí, cuándo fue la última?________ ¿Fue ❏ Positiva ❏ Negativa?
8. ❏ Sí ❏ No ¿Ha tenido jamás usted una mamografía? Si contestó sí, cuándo fue la última?________¿Fue normal?________

C. Historia Menstrual:

1. Su edad cuando tuvo su primera regla: ________
2. Su regla viene cada________días y dura ________ días.
3. Sus reglas son: ❏ Regulares ❏ Irregulares ❏ Dolorosas ❏ Ligeras ❏ Moderadas ❏ Pesadas
4. ❏ Sí ❏ No ¿Tiene sangrado entre periodos?

Provider notes:

www.familypact.org

Nombre **Edad** **Fecha de Nacimiento** **Fecha**

D. Historia de Embarazos:

Si nunca ha estado embarazada avance a la "Historia de Contracepción":
1. Número de: ____ Embarazos ____ Nacimientos vivos ____ Abortos espontáneos
   ____ Abortos inducidos ____ Nacimientos vivos
2. ¿Cuándo fue su último embarazo?________________Mes/año
3. ❑ Sí ❑ No ¿Está amamantando?

E. Historial de Contracepción:

1. ¿Edad que tuvo relaciones sexuales por la primera vez?____ años ❑ Nunca he tenido relaciones
2. ¿Qué importante es evitar el embarazo en este momento? ❑ Muy ❑ Algo ❑ No tan imporante
3. ¿Cuáles métodos anticonceptivos han usado usted y su pareja? ❑ Ninguno
   - A. ❑ Condones
   - B. ❑ Pastillas anticonceptivas
   - C. ❑ DepoProvera/Inyección
   - D. ❑ Patch
   - E. ❑ NuvaRing (anillo vaginal)
   - F. ❑ DUI (dispositivo)
   - G. ❑ Norplant
   - H. ❑ Diafragma/capa cervical
   - I. ❑ Ligadura de tubos/esterilización
   - J. ❑ Espuma, supositorios, crema, gel
   - K. ❑ Retiro/coito interrumpido
   - L. ❑ Ritmo/planificación natural
   - M. ❑ Pareja tuvo una vasectomía
4. ¿Cuáles tipos de contracepción usan usted y su pareja ahora?____________ ❑ Ninguna
5. ❑ Sí ❑ No ¿Está contenta con su método de planificación familiar?
6. Con qué frecuencia usa condones? ❑ Siempre ❑ A veces ❑ Nunca
7. ❑ Sí ❑ No ¿Ha usado alguna vez la pastilla anticonceptiva de emergencia (Plan B)?
8. ❑ Sí ❑ No ❑ Quizás ¿Desea salir embarazada en los próximos dos años?

F. Hábitos y Estilo de Vida:

Estas preguntas son personales. Si usted prefiere, puede hablar con su doctor/doctora sobre ellas.
1. ¿Cuántos vasos de alcohol toma por semana?____________ ❑ Ninguno
2. ❑ Sí ❑ No ¿Fuma cigarrillos? Si contestó sí, ¿Número de cigarrillos por día?________
3. ❑ Sí ❑ No ¿Toma drogas ilegales? Si contestó sí, lístelas aquí: ____________
4. ❑ Sí ❑ No ¿Ha usado drogas inyectadas?
5. ❑ Sí ❑ No ¿Ha compartido agujas?
6. ❑ Sí ❑ No ¿Le han dicho que tiene un problema con alcohol o drogas?
7. ❑ Sí ❑ No ¿Alguien (incluyendo su pareja), le ha amenazado o lastimado físicamente, o le ha causado que sienta miedo?
8. ❑ Sí ❑ No ¿Ha sido presionada o forceada a tener relaciones sexuales cuando no quería?
9. Ha tenido una pareja con historia de: ❑ Uso de drogas inyectadas ❑ Bisexualidad ❑ SIDA/VIH

G. Historia Sexual

En los ultimos 12 meses...
1. ❑ Sí ❑ No ¿Ha tenido relaciones sexuales? Si contestó no, avance a #7.
2. ¿Cuántas parejas sexuales tuvo en los últimos 12 meses?
3. ¿Ha tenido relaciones sexuales con: ❑ Hombres ❑ Mujeres ❑ Ambos?
4. ¿Ha tenido relaciones sexuales: ❑ Oral ❑ Anal ❑ Vaginal?
5. ❑ Sí ❑ No ¿Ha cambiado relaciones sexuales por dinero o drogas?
6. ❑ Sí ❑ No ¿Piensa que su pareja tiene otras parejas sexuales? ❑ No sé
7. ¿En los últimos 12 meses, ha tenido usted problemas con lo siguiente? Marque todo que aplique.
   - A. ❑ Clamídia
   - B. ❑ Gonorrea
   - C. ❑ Herpes Genitales
   - D. ❑ Tricomonas
   - E. ❑ Dolor o infección pélvica (PID)
   - F. ❑ Verrugas Genitales
   - G. ❑ Vaginosis Bacterial (BV)
   - H. ❑ Sífilis
   - I. ❑ Otro:__________
9. ❑ Sí ❑ No ¿Hay algo más sobre su salud sexual que desea consultar con su médico?

Provider notes:

www.familypact.org

Firma del paciente/Fecha   Firma del Médico/Fecha

FEMALE MEDICAL EXAM

Name ______ **Age** ______ **Date** ______

ALLERGIES ______ ❑ NKDA

SUBJECTIVE

Chief Complaint/Purpose of Visit: ______

G ______ P ______ TAB ______ SAB ______ Ectopic ______ LMP ______ LNMP ______
Current BCM ______ Since ______ Date of last pill/injection ______
Currently breast feeding? ❑ Yes ❑ No
BCM Desired ______
Last unprotected intercourse (UPIC) ______ EC used? ______
STD Risk Factors (past 12 months or since last visit/risk assessment): ❑ None ❑ Not assessed

- ❑ Known/suspected exposure
- ❑ New or >1 partner
- ❑ Possible non-monogamous partner
- ❑ Inconsistent condom use (<100%)
- ❑ Personal/partner IDU
- ❑ Hx of STD diagnosis

Staff signature: ______ Title: ______ Time: ______
Present history: ______

OBJECTIVE

Vital Signs: WT ______ HT ______ BMI ______ BP ______ T ______ P ______

PHYSICAL EXAM	NL	ABN	Not Done	Description
Neck/Thyroid				
Heart				
Lungs				
Breast ❑ BSE reviewed				
Abdomen				
GYN: Ext. Genitalia				
Urethral Meatus				
Urethra/Bladder				
Vagina				
Cervix				
Uterus				
Adnexae				
Anus/Perineum				

Other ______

Physical Exam Not Performed: ❑ Not Indicated ______ ❑ Patient declines ______
❑ Done elsewhere ❑ Records request

OFFICE TESTS

- ❑ Pregnancy Test
  - ❑ Positive
  - ❑ Negative
- ❑ Urinalysis
  - ❑ Leukocytes
  - ❑ Nitrites
  - ❑ Protein
  - ❑ Glucose
- ❑ Wet Mount
  - ❑ Candida
  - ❑ Trich
  - ❑ Clue Cells
  - ❑ WBC's: ______

Vaginal pH: ______ Amine **+** **-**

LAB TESTS

- ❑ Pap
- ❑ GC
- ❑ Syphilis
- ❑ GTT
- ❑ Lipids
- ❑ Urine C/S
- ❑ Herpes
- ❑ CT
- ❑ HIV
- ❑ Glucose
- ❑ Cholesterol
- ❑ LFTs
- ❑ CBC
- ❑ Mammo

Other lab tests: ______

EDUCATION

- ❑ Contraceptive Options
- ❑ Method: ______
  - ❑ Warning Signs/Risks
  - ❑ Side Effects
  - ❑ Usage
- ❑ Emergency Contraception (EC)
- ❑ Condoms/spermicides
- ❑ Safer Sex/STI
- ❑ Alcohol/Drug Use
- ❑ Preconception Planning
- ❑ Parental Involvement (if <18)
- ❑ Mammogram (if >40)

MEDICAL DECISION MAKING

Assessment: ______

Plan: ❑ BCM ______

❑ Referral/ ❑ Consultation ______ ❑ RTC ______ /PRN
Rx dispensed ______
>50% of visit was counseling/coordination of care. Clinician time:

Clinician signature: ______

Print Name ______ Date/Time ______

www.familypact.org

03-07

FEMALE MEDICAL EXAM

Name ______ **Age** ______ **Date** ______

ALLERGIES ______ ❑ NKDA

SUBJECTIVE

Chief Complaint/Purpose of Visit: ______

G ______ P ______ TAB ______ SAB ______ Ectopic ______ LMP ______ LNMP ______

Current BCM ______ Since ______ Date of last pill/injection ______

Currently breast feeding? ❑ Yes ❑ No

BCM Desired ______

Last unprotected intercourse (UPIC) ______ EC used? ______

STD Risk Factors (past 12 months or since last visit/risk assessment): ❑ None ❑ Not assessed

- ❑ Known/suspected exposure
- ❑ New or >1 partner
- ❑ Possible non-monogamous partner
- ❑ Inconsistent condom use (<100%)
- ❑ Personal/partner IDU
- ❑ Hx of STD diagnosis

Staff signature: ______ Title: ______ Time: ______

Present history: ______

OBJECTIVE

Vital Signs: WT ______ HT ______ BMI ______ BP ______ T ______ P ______

PHYSICAL EXAM	NL	ABN	Not Done	Description
Neck/Thyroid				
Heart				
Lungs				
Breast ❑ BSE reviewed				
Abdomen				
GYN: Ext. Genitalia				
Urethral Meatus				
Urethra/Bladder				
Vagina				
Cervix				
Uterus				
Adnexae				
Anus/Perineum				

Other ______

Physical Exam Not Performed: ❑ Not Indicated ______ ❑ Patient declines ______
❑ Done elsewhere ❑ Records request

MEDICAL DECISION MAKING

Assessment: ______

Plan: ❑ BCM ______

❑ Referral/ ❑ Consultation ______ ❑ RTC ______/PRN

Rx dispensed ______

>50% of visit was counseling/coordination of care. Clinician time:

OFFICE TESTS

- ❑ Pregnancy Test
  - ❑ Positive
  - ❑ Negative
- ❑ Urinalysis
  - ❑ Leukocytes
  - ❑ Nitrites
  - ❑ Protein
  - ❑ Glucose
- ❑ Wet Mount
  - ❑ Candida
  - ❑ Trich
  - ❑ Clue Cells
  - ❑ WBC's: ______

Vaginal pH: ______ Amine **+ -**

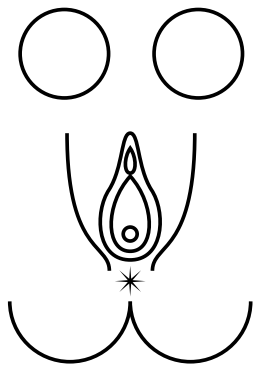
LAB TESTS

- ❑ Pap
- ❑ GC
- ❑ Syphilis
- ❑ GTT
- ❑ Lipids
- ❑ Urine C/S
- ❑ Herpes
- ❑ CT
- ❑ HIV
- ❑ Glucose
- ❑ Cholesterol
- ❑ LFTs
- ❑ CBC
- ❑ Mammo

Other lab tests: ______

EDUCATION

- ❑ Contraceptive Options
- ❑ Method: ______
  - ❑ Warning Signs/Risks
  - ❑ Side Effects
  - ❑ Usage
- ❑ Emergency Contraception (EC)
- ❑ Condoms/spermicides
- ❑ Safer Sex/STI
- ❑ Alcohol/Drug Use
- ❑ Preconception Planning
- ❑ Parental Involvement (if <18)
- ❑ Mammogram (if >40)



Clinician signature: ______

Print Name ______ Date/Time ______

www.familypact.org

Name **Age** **Date of Birth** **Date**

MALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

❏ Yes ❏ No Are you allergic to any medications? List here:

❏ Yes ❏ No Do you take any over the counter medicines, prescription medicines, vitamins, supplements, steroids or home remedies? List here:

❏ Yes ❏ No Do you have a usual source of primary care? If yes, who?

Provider notes:

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

1. ❏ Heart attack/disease
2. ❏ Stroke
3. ❏ Blood clots in legs/lungs
4. ❏ High blood pressure
5. ❏ High cholesterol
6. ❏ Diabetes
7. ❏ Alcohol or drug abuse
8. ❏ Birth defects/Genetic problems
9. ❏ Mental illness
10. ❏ Maternal DES exposure
11. ❏ Cancer
12. ❏ I do not know my family medical history

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ❏ Heart disease
B. ❏ High blood pressure
C. ❏ Stroke
D. ❏ Diabetes
E. ❏ High cholesterol
F. ❏ Tuberculosis (TB)
G. ❏ Asthma
H. ❏ Blood clot in leg/lungs
I. ❏ Bleed/bruise easily
J. ❏ Anemia
K. ❏ Sickle cell disease
L. ❏ Kidney/bladder problems
M. ❏ Seizures or epilepsy
N. ❏ Depression
O. ❏ Suicidal thoughts
P. ❏ Mental illness
Q. ❏ Severe headaches or migraines
R. ❏ Liver problems/ Hepatitis
S. ❏ Gall bladder disease
T. ❏ Eating disorder
U. ❏ Cancer Type: ____________
V. ❏ Thyroid disease
W. ❏ Infertility

2. ❏ Yes ❏ No Have you ever been hospitalized or had any surgery? If yes, when and why? ____________
3. ❏ Yes ❏ No Have you ever had a transfusion or blood exposure?
4. ❏ Yes ❏ No Have you been immunized against rubella? ❏ Don't know
5. ❏ Yes ❏ No Have you been immunized against Hepatitis B? ❏ Don't know
6. When was your last genital exam?____________ ❏ Never had a genital exam
   ❏ Yes ❏ No Were you ever told there was any problem? If yes, what?____________
7. ❏ Yes ❏ No Have you ever had an HIV test?____________
   If yes, when was your last one?____________ Was it ❏ Positive ❏ Negative?

C. Contraception History:

1. How old were you when you first had intercourse? ______ years old ❏ Never had sex
2. How important is it for you to avoid pregnancy now? ❏ Very ❏ Somewhat ❏ Not at all
3. What birth control methods have you and your partners used in the past? ❏ None

A. ❏ Condoms/rubbers
B. ❏ Birth control pills
C. ❏ DepoProvera/Shot
D. ❏ Patch
E. ❏ NuvaRing (vaginal ring)
F. ❏ IUD
G. ❏ Implants under the skin
H. ❏ Diaphragm/cervical cap
I. ❏ Tubal ligation/tubes tied
J. ❏ Foam/Film or Jelly
K. ❏ Withdrawal/pulling out
L. ❏ Rhythm method
M. ❏ Vasectomy

4. What birth control are you and your partner(s) currently using?____________ ❏ None
5. ❏ Yes ❏ No Are you happy with your method?
6. How often do you use condoms? ❏ Always ❏ Sometimes ❏ Never
7. ❏ Yes ❏ No Have you ever used emergency contraception (morning after pill/Plan B)?
8. ❏ Yes ❏ No ❏ Maybe Are you and your partner planning to get pregnant in the next two years?
9. ❏ Yes ❏ No Have you ever gotten anyone pregnant? ❏ Unsure

www.familypact.org

Name **Age** **Date of Birth** **Date**

D. Habits and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? ____________ ❑ None
2. ❑Yes ❑ No Do you smoke cigarettes? If yes, how many cigarettes per day? ____________
3. ❑Yes ❑ No Do you use any street drugs? If yes, please list: ____________
4. ❑Yes ❑ No Have you ever used injected drugs?
5. ❑Yes ❑ No Have you ever shared needles?
6. ❑Yes ❑ No Has anyone ever told you that you have a problem with drugs or alcohol?
7. ❑Yes ❑ No Is anyone, including your partner, threatening you, causing you to be afraid or hurting you physically?
8. ❑Yes ❑ No Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of: ❑ Injected drug use ❑ HIV

E. Sexual History

In the last 12 months...

1. ❑Yes ❑ No Have you been sexually active? If no, skip to #6.
   If yes, how many sexual partners have you had? ____________
2. Have you had sex with ❑ Men ❑ Women ❑ Both?
3. Have you and/or your partner(s) had ❑ Oral sex ❑ Anal sex ❑ Vaginal sex?
4. ❑Yes ❑ No Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   ❑ Yes, definitely ❑ Not sure, possibly ❑ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
   A. ❑ Chlamydia D. ❑ Trichomoniasis (Trich) G. ❑ Syphilis
   B. ❑ Gonorrhea E. ❑ Pelvic Inflammatory Disease H. ❑ Other: ____________
   C. ❑ Genital Herpes F. ❑ Genital Warts

7. ❑Yes ❑ No Is there anything else about your health or sexual practices that you would like to discuss with your clinician? ____________

Provider notes:

Patient Signature/Date

Clinician Signature/Date

www.familypact.org

03-07

Nombre **Edad** **Fecha de Nacimiento** **Fecha**

HISTORIA MÉDICA PARA HOMBRES

Esta información es confidencial y será utilizada por su proveedor médico para asegurar que usted obtenga el cuidado apropiado.

❑ Sí ❑ No ¿Es usted alérgico a medicamentos? Si contestó sí, listelos aqui:

❑ Sí ❑ No ¿Usted toma medicamentos, suplementos, vitaminas, o remedios caseros? Si contestó sí, listelos aqui:

❑ Sí ❑ No ¿Tiene un doctor que la atiende normalmente? Si contestó sí, quién es?

A. Historia Médica Familiar:

¿Ha tenido alguien en su familia problemas con lo siguiente? (madre, padre, abuelos, hermanos):

1. ❑ Enfermedad del corazón
2. ❑ Derrame cerebral
3. ❑ Coágulos de sangre en las piernas o pulmones
4. ❑ Alta presión
5. ❑ Colesterol alto
6. ❑ Diabetes
7. ❑ Problemas con alcohol o drogas
8. ❑ Defectos de nacimiento
9. ❑ Problemas psiquiátricos
10. ❑ Cáncer
11. ❑ Expuesta a DES
12. ❑ No conozco mi historial médica familiar

B. Historia Médica Personal:

1. ¿Ha tenido USTED problemas con lo siguiente? Marque todo que aplique.

A. ❑ Enfermedad del corazón
B. ❑ Alta presión
C. ❑ Derrame cerebral
D. ❑ Diabetes
E. ❑ Colesterol alto
F. ❑ Tuberculosis (TB)
G. ❑ Asma
H. ❑ Coágulos de sangre en las piernas o pulmones
I. ❑ Hemorragias/coagulación
J. ❑ Anemia
K. ❑ Anemia drepanocítica
L. ❑ Infertilidad
M. ❑ Problemas del riñón/vejiga
N. ❑ Convulsiones o epilepsia
O. ❑ Depresión
P. ❑ Pensamientos suicidas
Q. ❑ Problemas psiquiátricos
R. ❑ Dolores de cabeza severos o migraña
S. ❑ Problema del higado/ Hepatitis
T. ❑ Enfermedad de la vesícula biliar
U. ❑ Desórdenes alimenticios
V. ❑ Cáncer, Típo:__________
W. ❑ Tiroides

2. ❑ Sí ❑ No ¿Ha estado hospitalizado o ha tenido cirugía? Si contesto sí, ¿cuándo y por qué?__________
3. ❑ Sí ❑ No ¿Ha tenido una transfusión o contacto con sangre?
4. ❑ Sí ❑ No ¿Ha sido inmunizado contra rubella? ❑ No sé
5. ❑ Sí ❑ No ¿Ha sido inmunizado contra Hepatitis B? ❑ No sé
6. ¿Cuándo fue su último examen genital?__________ ❑ Nunca he tenido uno
   ❑ Sí ❑ No ¿Le detectaron algún problema? Si contestó sí, que fue? __________
7. ❑ Sí ❑ No ¿Ha tenido jamás usted una prueba de VIH? Si contestó sí, cuándo fue la última?__________ ¿Fue ❑ Positiva ❑ Negativa?

Provider notes:

www.familypact.org

Nombre **Edad** **Fecha de Nacimiento** **Fecha**

C. Historial de Contracepción:

1. ¿Edad que tuvo relaciones sexuales por la primera vez? _____ años ❑ Nunca he tenido relaciones
2. ¿Qué importante es evitar el embarazo en este momento? ❑ Muy ❑ Algo ❑ No tan imporante
3. ¿Cuáles métodos anticonceptivos han usado usted y su pareja? ❑ Ninguno
   - A. ❑ Condones
   - B. ❑ Pastillas anticonceptivas
   - C. ❑ DepoProvera/Inyección
   - D. ❑ Patch
   - E. ❑ NuvaRing (anillo vaginal)
   - F. ❑ DUI (dispositivo)
   - G. ❑ Norplant
   - H. ❑ Diafragma/capa cervical
   - I. ❑ Ligadura de tubos/esterilización
   - J. ❑ Espuma, supositorios, crema, gel
   - K. ❑ Retiro/coito interrumpido
   - L. ❑ Ritmo/planificación natural
   - M. ❑ Vasectomía
4. ¿Cuáles tipos de contracepción usan usted y su pareja ahora? _______________ ❑ Ninguna
5. ❑ Sí ❑ No ¿Está contento con su método de planificación familiar?
6. Con qué frecuencia usa condones? ❑ Siempre ❑ A veces ❑ Nunca
7. ❑ Sí ❑ No ¿Su pareja ha usado alguna vez la pastilla anticonceptiva de emergencia (Plan B)?
8. ❑ Sí ❑ No ❑ Quizás ¿Desea tener hijos en los próximos dos años?

D. Hábitos y Estilo de Vida:

Estas preguntas son personales. Si usted prefiere, puede hablar con su doctor/doctora sobre ellas.

1. ¿Cuántos vasos de alcohol toma por semana?____________________ ❑ Ninguno
2. ❑ Sí ❑ No ¿Fuma cigarrillos? Si contestó sí, ¿Número de cigarrillos por día?__________
3. ❑ Sí ❑ No ¿Toma drogas ilegales? Si contestó sí, lístelas aquí: ____________________
4. ❑ Sí ❑ No ¿Ha usado drogas inyectadas?
5. ❑ Sí ❑ No ¿Ha compartido agujas?
6. ❑ Sí ❑ No ¿Le han dicho que tiene un problema con alcohol o drogas?
7. ❑ Sí ❑ No ¿Alguien (incluyendo su pareja), le ha amenazado o lastimado físicamente, o le ha causado que sienta miedo?
8. ❑ Sí ❑ No ¿Ha sido presionado o forceado a tener relaciones sexuales cuando no quería?
9. Ha tenido una pareja con historia de: ❑ Uso de drogas inyectadas ❑ Bisexualidad ❑ SIDA/VIH

E. Historia Sexual

En los ultimos 12 meses...

1. ❑ Sí ❑ No ¿Ha tenido relaciones sexuales? Si contestó no, avance a #7.
2. ¿Cuántas parejas sexuales tuvo en los últimos 12 meses?__________________
3. ¿Ha tenido relaciones sexuales con: ❑ Hombres ❑ Mujeres ❑ Ambos?
4. ¿Ha tenido relaciones sexuales: ❑ Oral ❑ Anal ❑ Vaginal?
5. ❑ Sí ❑ No ¿Ha cambiado relaciones sexuales por dinero o drogas?
6. ❑ Sí ❑ No ¿Piensa que su pareja tiene otras parejas sexuales? ❑ No sé
7. ¿En los últimos 12 meses, ha tenido usted problemas con lo siguiente? Marque todo que aplique.
   - A. ❑ Clamídia
   - B. ❑ Gonorrea
   - C. ❑ Herpes Genitales
   - D. ❑ Tricomonas
   - E. ❑ Verrugas Genitales
   - F. ❑ Sífilis
   - I. ❑ Otro:__________
8. ❑ Sí ❑ No ¿Hay algo más sobre su salud sexual que desea consultar con su médico?

____

____

____

Provider notes:

www.familypact.org

______________________________ Firma del paciente/Fecha

______________________________ Firma del Médico/Fecha

MALE MEDICAL EXAM

Name **Age** **Date**

ALLERGIES ________________________ ❑ NKDA

SUBJECTIVE

Chief Complaint/Purpose of Visit: ________________________

Number of pregnancies caused ________ Number of biological children ________

BCM Desired ________________________

Last unprotected intercourse (UPIC) ________________________

STD Risk Factors (past 12 months or since last visit/risk assessment): ❑ None ❑ Not assessed

- ❑ Known/suspected exposure
- ❑ Inconsistent condom use (<100%)
- ❑ New or >1 partner
- ❑ Personal/partner IDU
- ❑ Possible non-monogamous partner
- ❑ Hx of STD diagnosis

Staff signature: ____________ Title: ________ Time: ________

Present history: ________________________

OBJECTIVE

Vital Signs: WT________ HT________ BMI ________ BP ________ T ________ P ________

PHYSICAL EXAM	NL	ABN	Not Done	Description
HEENT				
Neck/Thyroid				
Heart				
Lungs				
Abdomen				
GU: Groin				
Scrotum/Testes				
Penis				
Perenium				
Anus/Rectum				
Urethra				
Lymph				

Other ________________________

Physical Exam Not Performed: ❑ Not Indicated ________ ❑ Patient declines ________

❑ Done elsewhere ❑ Records request

OFFICE TESTS

- ❑ Urinalysis*
  - ❑ Leukocytes
  - ❑ Nitrites
  - ❑ Protein
  - ❑ Glucose
- ❑ Gram Stain

LAB TESTS

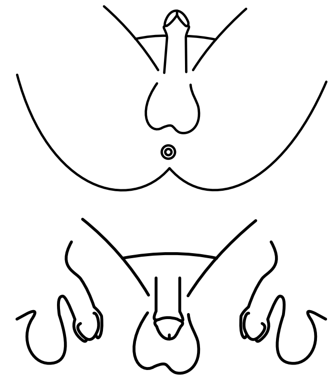
- ❑ CT
- ❑ GC
- ❑ HIV
- ❑ Syphilis
- ❑ Herpes
- ❑ Urine C/S*

Other lab tests: ________

* Not a FPACT benefit for men

EDUCATION

- ❑ Contraceptive Options
- ❑ Vasectomy
- ❑ Emergency Contraception (EC)
- ❑ Condoms/spermicides
- ❑ Safer Sex/STI
- ❑ Alcohol/Drug Use
- ❑ Preconception Planning
- ❑ Parental Involvement (if <18)



MEDICAL DECISION MAKING

Assessment: ________________________

Plan: ❑ BCM ________________________

❑ Referral/ ❑ Consultation ________________________ ❑ RTC________/PRN

Rx dispensed ________________________

>50% of visit was counseling/coordination of care. Clinician time:

Clinician signature: ________________________

Print Name ________________ Date/Time ________________

www.familypact.org

03-07

CLINICAL PRACTICE

ALERT

May 2007

Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

PROVIDING CLINICAL SERVICES TO FEMALE ADOLESCENTS

While most reproductive health care services offered to adolescents are similar to those provided to adult women, there are differences in specific interventions provided to younger women. For the purpose of this Clinical Practice Alert, a "female adolescent" is defined as a woman under 21 years old.

KEY POINTS

- **"Quick Start" regimens for new starters of hormonal contraceptive methods improve the likelihood of successful contraceptive initiation and continuation when compared to conventional "new start" regimens.**
- **Make emergency contraception available to adolescents by advance provision. Doing so does not increase the likelihood of risk-taking behaviors, either for sexually transmitted infections (STIs) or pregnancy risks.**
- **Initiate Pap smear screening *three years* after a women's first episode of vaginal intercourse or by 21 years old when the time of onset of vaginal intercourse is unknown.**
- **Offer a supply of condoms in conjunction with hormonal contraceptives to women at risk for STIs.**
- **It is strongly recommended to screen adolescents for intimate partner (and dating) violence.**

QUESTIONS AND ANSWERS

At what age can an adolescent give consent for Family PACT services?

A minor of any age may receive birth control services without parental consent. A minor must be at least 12 years old to request testing or treatment for sexually transmitted infections. California law requires parental consent for certain surgical procedures and immunizations for those under age 18. (See *Resources for Information on Adolescent Health Care* on the reverse side.)

What is a "Quick Start" regimen and why is it important for adolescents?

Adolescents are more likely to be effective users of hormonal contraception if they can initiate the method right away regardless of time in the menstrual cycle. A woman who starts oral contraceptives, Ortho Evra® patch or NuvaRing® after day six of her menstrual cycle should use condoms for the next seven days and consider emergency contraception if she has had unprotected intercourse beyond day six. A urine pregnancy test also should be done if an early pregnancy is possible and at least 10 days have passed since the earliest day of ovulation.

Can an adolescent use an intrauterine contraceptive (IUC) such as Mirena® or ParaGard®?

Yes, IUCs are excellent methods of contraception for adolescents. Keep in mind that insertion may be more difficult in women who have never been pregnant and that expulsion rates are slightly higher.

How often should asymptomatic adolescents be screened for chlamydia (Ct) and gonorrhea (GC)?

Perform routine screening for Ct annually in all sexually active females 25 years of age and younger. If the prevalence of GC in your client population is *known* to be less than one percent, routine screening for GC is not necessary. Otherwise, targeted screening for Ct and GC in females, and for males of any age, is restricted to those with risk factors.

Should I screen my adolescent clients for oral or anal Ct or GC?

Heterosexual adolescents who engage in oral or anal sex and who are asymptomatic should not be screened routinely for either oropharyngeal or anorectal GC or Ct. In addition, nucleic acid amplification test (NAAT) and DNA probe GC and Ct tests are not Food and Drug Administration-approved for collection from non-genital sources, unless equivalence with culture has been validated by your laboratory.

If an adolescent isn't due for a Pap smear, is a pelvic exam necessary at the time of a check-up visit?

If the client is asymptomatic and Ct (with or without GC) screening can be done with a NAAT using a urine sample or self-administered vaginal swab, there is no reason to perform a pelvic examination.

How should atypical squamous cells of undetermined significance (ASC-US) and low-grade squamous intraepithelial lesions (LSIL) Pap smear results be managed?

Adolescents with ASC-US or LSIL Pap results should receive repeat cytology at 6 and 12 months from the initial result or a human papilloma virus (HPV) DNA test at 12 months, since HPV infections are likely to be transient and will resolve quickly. Therefore, "reflex HPV test for ASC-US" should ***not*** be ordered when submitting the Pap smear request to the laboratory as management is the same whether the HPV test is positive or negative. The lower age for HPV test reimbursement is 15 years.

Is management of biopsy-proven cervical intraepithelial neoplasia (CIN) different for adolescents?

In adolescents, CIN 2 lesions have a high regression rate, and therefore act more like CIN 1 lesions. The American College of Obstetricians and Gynecologists (ACOG) guidelines recommend that adolescents with biopsy proven CIN 2 be observed and treated only if the lesion persists or progresses.

PROVIDING CLINICAL SERVICES TO FEMALE ADOLESCENTS (CONT.)

How can I improve teen males' participation in STI testing?

Many males avoid STI testing out of embarrassment and fear of painful physical evaluation. Family PACT recommends urine-based NAATs for Ct and GC rather than urethral swabs.

Is parental involvement desirable?

Girls whose mothers are aware and supportive of their clinic visits are more likely to have better contraceptive use. Talk with teens at their initial visit about communication with their families or a trusted adult about sexual health issues. Provide literature about parent-child communication, while carefully protecting adolescents' confidentiality.

Should I assess for sexual abuse and dating violence?

The Society for Adolescent Medicine suggests that clinicians should ask sensitive questions to allow teens the opportunity to discuss sexual abuse. Adolescents also should be counseled about personal safety, risk-taking behaviors, and use of preventive measures. Dating violence should be assessed in both male and female clients.

APPLICATION OF FAMILY PACT STANDARDS

1. **Informed Consent**
   - A minor of any age can consent to medical care related to the prevention and treatment of pregnancy.
   - The consent process shall be provided in a language understood by the client and supplemented with written materials.
2. **Confidentiality**
   - Contraceptive services shall be provided confidentially.
   - Clients shall be advised that California law mandates reporting of human immunodeficiency virus, syphilis, pelvic inflammatory disease, GC, and Ct to the local health jurisdiction for prevention, control, and, in some cases, contact management. Client information shall be reported on the Confidential Morbidity Report within seven days of identification.
3. **Access to Care**
   - Contraceptive and STI services shall be provided without cost to all Family PACT clients.
   - Referral resources for medical and psychosocial services beyond the scope of Family PACT, including domestic violence and substance abuse, shall be made available to clients. Services not listed in the Family PACT *Policy, Procedures, and Billing Instructions* (PPBI) are not reimbursable by the program.
4. **Availability of Covered Services**
   - Family PACT providers must provide access to, or referral for, contraceptives, including oral emergency contraceptives, listed in the PPBI and offer timely, basic STI prevention and management onsite.
   - Screening, testing, and treatment for STIs as listed in the PPBI shall be made available to clients as a condition of delivering services under Family PACT.
5. **Scope of Clinical and Preventive Services**
   - Clinicians delivering services are expected to have professional knowledge and skills about medical practice standards pertaining to contraceptive services and STI prevention and management services.
   - Routine physical examination at periodic health screening visits is not required, unless clinically indicated.
   - Documentation shall record clinical findings and justification for services in medical record.
6. **Education and Counseling Services**
   - Clients shall receive education on protecting their reproductive health and plans for future pregnancy.
   - Client-centered prevention and STI and HIV risk-reduction counseling and education shall be provided.
   - Individual education and counseling shall be provided for all clients as set forth in the PPBI.

PROGRAM POLICY

This Alert provides an interpretation of the Family PACT Standards regarding care of adolescent clients: Providers should refer to the Family PACT PPBI for the complete text of the Family PACT Standards, official administrative practices, and billing information. For the purposes of this and other Family PACT Clinical Practice Alerts, the term "shall" indicates a program requirement; the term "should" is advisory and not required.

RESOURCES FOR INFORMATION ON ADOLESCENT HEALTH CARE

- ACOG Committee Opinion: *Evaluation and Management of Abnormal Cytology in Adolescents*. Obstet Gynecol 2006;107:963-68
- *Making your practice teen-friendly.* Available at http://www.metrokc.gov/health/famplan/tfriendly/tfriendly.htm.
- *Parental involvement and communication.* Available at http://www.talkwithyourkids.org.
- *Youth Friendly Services: A Manual for Services Providers.* Available at http://www.engenderhealth.org/res/offc/qi/yfs/.
- *Sexual Health: An Adolescent Provider Toolkit*; Adolescent Health Working Group. Available at http://ahwg.net/resources/SexualHealthCA-Final1103.pdf.
- *California Minor Consent Laws.* Available at http://www.youthlaw.org/child_welfare/.
- *Protecting Adolescents Ensuring Access to Care and Reporting Sexual Activity and Abuse*; *Reproductive Health Care for Adolescents*; and *Provision of Emergency Contraception to Adolescents*; The Society for Adolescent Medicine. Available at http://www.adolescenthealth.org/PositionPapers.htm.