NORTH DAKOTA CLINIC VISIT RECORD

CLINIC # _____ CLIENT # |_|_|_|_|_|_|_|_| D.O.B. |_|_| – |_|_| – |_|_|_|_| GENDER: F M ZIP _____

ANNUAL INCOME _____ HOUSEHOLD SIZE _____ BP ___/___ HEIGHT (inches) _____ WEIGHT (pounds) _____

SEXUAL ORIENTATION

☐ 1. Bisexual ☐ 3. Straight/Heterosexual ☐ 5. Unknown
☐ 2. Lesbian/Gay/Homosexual ☐ 4. Other/Something Else ☐ 6. Declined to Disclose

GENDER IDENTITY

☐ 01. Male ☐ 05. Other
☐ 02. Female ☐ 06. Neither M/F Exclusively
☐ 03. Female to Male/Trans Male ☐ 07. Declined to Disclose
☐ 04. Male to Female/Trans Female ☐ 08. Unknown

TOBACCO STATUS (check one):

☐ 1. Current Every Day ☐ 3. Former
☐ 2. Current Some Day ☐ 4. Never

RACE (check all that apply)

☐ 1. White ☐ 4. Asian
☐ 2. Black or African American ☐ 5. Pacific Is./Hawaiian
☐ 3. Am. Ind./Alaskan ☐ 6. Unknown/Unreported

LIMITED ENGLISH PROFICIENCY ☐ Y ☐ N

HISPANIC ☐ Y ☐ N ☐ Unknown/Not Reported

4. VISIT DATE |_|_| – |_|_| – 2 0 |_|_|

5. PRIMARY SOURCE OF PAYMENT (check one)

☐ 1. No Fee ☐ 5. Private Insurance
☐ 2. Partial Fee ☐ 6. Other Govt. Ins. (Military, VA)
☐ 3. Full Fee ☐ 7. Medicare
☐ 4. Medicaid (Traditional or Expansion) ☐ 8. Women's Way

6. CLIENT INSURANCE STATUS (check one)

☐ 1. Medicaid (Traditional) ☐ 5. Uninsured
☐ 3. Medicaid (Expansion) ☐ 7. Other Govt. Ins. (Military, VA)
☐ 2. Private Health Insurance ☐ 8. Medicare
☐ 4. Women's Way

7. PURPOSE OF VISIT (check one)

☐ 1. Preventive Health Visit (New Client) ☐ 5. STD Screening/Tx
☐ 6. Contraceptive Surveillance
☐ 2. Preventive Health Visit (Established Client) ☐ 7. Education/Counseling
☐ 8. Pregnancy Test
☐ 3. Medical Visit ☐ 9. Supply Visit
☐ 4. Problem Visit

16. TELEMEDICINE ENCOUNTER? ☐ Y ☐ N

8. PRIMARY METHOD (Complete before and after blocks)

01. Sterile Male
02. Sterile Female
03. Orals - Combined
23. Orals – Progestin Only
04. IUD/Unspecified
21. IUD w/Progestin
22. IUD Copper
05. FAM
24. LAM
06. Implantable Rod
07. Condom (male)
08. Condom (female)
09. Spermicide
10. Diaphragm
11. Injectables
12. Contraceptive Patch
13. Vaginal Ring
14. Sponge
15. Withdrawal
17. EC
18. Cervical Cap
19. None
20. Decline to Answer

Before Visit ☐☐ After Visit ☐☐

9. IF NO METHOD GIVE REASON

☐ 1. Abstinence ☐ 4. Infertility
☐ 2. Seeking Pregnancy ☐ 6. Other
☐ 3. Same Sex Partner

Before Visit ☐ After Visit ☐

17. HOW CONTRACEPTIVE METHOD WAS PROVIDED:

☐ 1. Provided on site ☐ 4. Provided Elsewhere
☐ 2. Referral ☐ 5. N/A
☐ 3. Prescription

18. PREGNANCY STATUS

☐ 1. Pregnant
☐ 2. Not Pregnant
☐ 3. Unknown

19. PREGNANCY INTENTION

☐ 1. Yes
☐ 2. Okay either way
☐ 3. No
☐ 4. Unsure

10. PROVIDERS OF MEDICAL/COUNSELING SERVICES

☐ 1. Physician |_|_|_| ☐ 4. CNM |_|_|_|
☐ 2. Nurse Prac. |_|_|_| ☐ 5. PA |_|_|_|
☐ 3. RN ☐ 6. Other (LPN, MA, etc.)

11. MEDICAL SERVICES PROVIDED

☐ 01. Bv Tx
☐ 02. Blood Pressure
☐ 03. Candida Tx
☐ 04. CBE
☐ 05. Diaph/Cap Fit/Chk
☐ 06. Chlamydia Tx
☐ 07. Colpo/Cryo
☐ 08. Contracep. Refill
☐ 09. Syphillis Tx
☐ 10. 3-Month Injection
☐ 11. Herpes Tx
☐ 12. EC
☐ 13. Gonorrhea Tx
☐ 14. Height/Weight
☐ 15. HPV Tx
☐ 16. HPV Vaccine
☐ 17. Implant Insert
☐ 18. Implant Removal
☐ 19. IUD Insertion
☐ 20. IUD Removal
☐ 21. IUD Check
☐ 22. Medical Hx
☐ 23. Molluscum Tx
☐ 24. Pelvic Exam
☐ 25. Phys. Assess
☐ 26. Contraceptive Change
☐ 27. Testicular Exam
☐ 28. Trich. Tx
☐ 29. UTI Tx

12. LAB SERVICES PROVIDED

☐ 30. Blood Glucose
☐ 31. CBC
☐ 32. Chlamydia Test
☐ 33. Gonorrhea Test
☐ 34. Hemoglobin
☐ 35. Hepatitis B
☐ 36. Hepatitis C
☐ 37. Herpes Test
☐ 38. HIV Test
☐ 39. HPV Typing
☐ 40. Lipid Profile
☐ 41. Metabolic Panel
☐ 42. Pap Smear
☐ 43. Ph Test/Rapid BV
☐ 44. Neg. Preg. Test
☐ 45. Pos. Preg. Test
☐ 46. Repeat Pap.
☐ 47. Syphilis Test
☐ 48. Stool Occult
☐ 49. Trich. Rapid
☐ 50. TSH/T4
☐ 51. Urinalysis
☐ 52. Wet Mount
☐ 53. Mycoplasma Genitalia
☐ 54. Monkeypox Test

14. COUNSELING SERVICES PROVIDED

☐ 61. Safe Sex Edu.
☐ 62. Blood Pressure
☐ 63. Colorectal Scrn.
☐ 64. Contraception
☐ 65. Domestic Viol.
☐ 66. Exercise
☐ 67. FAM/LAM
☐ **68. Female Exam**
☐ 69. Genetic Counsel
☐ 70. HIV
☐ 71. Immunizations
☐ 72. Infertility
☐ **73. Male Exam**
☐ 74. Mental Health
☐ 75. Nutrition
☐ 76. Obesity
☐ 77. Pap Follow-Up
☐ **78. Preconception**
☐ 79. Pregnancy
☐ 80. Rape Crisis/Abuse
☐ 81. Req. Adol. Counsel
☐ 82. Breast Awareness
☐ 83. Sterilization
☐ 84. Substance Abuse
☐ 85. STD Follow-Up
☐ 86. Tobacco
☐ 87. Genital Awareness
☐ 88. PHQ-2
☐ 89. PHQ-9
☐ 90. Reprod. Life Plan
☐ 91. Achieve Pregnancy

15. REFERRED ELSEWHERE (check all applicable)

☐ 01. Abnormal Pap
☐ 02. Breast Concerns
☐ 03. Domestic Violence
☐ 04. FAM/LAM
☐ 05. HIV Services/Screening
☐ 06. Infertility
☐ 07. Mental Health
☐ 19. Nat. Lifeline (fax)
☐ 20. Priv. Counselor
☐ 21. Human Svcs. Center
☐ 22. Taken to Hospital
☐ 23. Provider Counseled
☐ 24. None Warranted (PHQ-2 or 9)
☐ 25. Client Declined
☐ 08. Nutritional Services
☐ 10. Other – Medical
☐ 11. Positive Pregnancy
☐ 12. Rape Crisis/Abuse
☐ 13. Social Services
☐ 14. Sterilization
☐ 15. Substance Abuse
☐ 16. Tobacco Cessation
☐ 17. WIC
☐ 18. Women's Way
☐ 26. Ryan White

20. DO YOU WANT TO TALK ABOUT CONTRACEPTION OR PREGNANCY TODAY?

☐ 01. Yes – I want to talk about contraception.
No – I don't want to talk about contraception:
☐ 02. I'm here for something else.
☐ 03. This question doesn't apply to me.
☐ 04. I prefer not to answer.
☐ 05. I'm already using contraception.
☐ 06. I'm unsure or don't want to use contraception.
☐ 07. I'm hoping to become pregnant in the near future.