NORTH DAKOTA CLINIC VISIT RECORD

COMPLETE AT FIRST VISIT, UPDATE FOR CHANGES AND AT ANNUAL EXAM

CLINIC NO._____

CLIENT NUMBER _____ DATE OF BIRTH __-__-__ GENDER: F M CONTACT STATUS_____

YEARS OF EDUCATION _____ ANNUAL INCOME_____

HOUSEHOLD SIZE_____ ZIP_____

TOBACCO USER ☐ Y ☐ N ☐ New Patient ☐ Established Patient

COMPLETE AT FIRST VISIT ONLY

RACE (check all that apply)

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

LIMITED ENGLISH PROFICIENCY: ☐ Y ☐ N

HISPANIC ☐ Y ☐ N ☐ Unknown/Not Reported

COMPLETE AT EACH VISIT

4. VISIT DATE __-__-20__

5. PRIMARY SOURCE OF PAYMENT (check one)

- ☐ 1. No Fee
- ☐ 2. Partial Fee
- ☐ 3. Full Fee
- ☐ 4. Title XIX
- ☐ 5. Private Insurance

6. CLIENT INSURANCE STATUS (check one)

- ☐ 1. Public Health Insurance
- ☐ 2. Private Health Insurance
- ☐ 5. Uninsured
- ☐ 6. Unknown

7. PURPOSE OF VISIT (check one)

- ☐ 1. Initial Exam
- ☐ 2. Annual Exam
- ☐ 3. Medical Visit
- ☐ 4. Problem Visit
- ☐ 5. STD/Infection
- ☐ 6. Contraceptive Surveillance
- ☐ 7. Education/Counseling
- ☐ 8. Pregnancy Test
- ☐ 9. Supply Visit

8. CONTRACEPTIVE METHOD (Complete before and after blocks)

11. 3-Month Injection	04. IUD/IUS
16. Abstinence	19. None
18. Cervical Cap	03. Orals
08. Condom (female)	20. Other
07. Condom (male)	09. Spermicide
10. Diaphragm	14. Sponge
17. EC	02. Sterile Female
05. FAM/LAM	01. Sterile Male
06. Hormonal Implant	13. Vaginal Ring
12. Hormonal Patch	15. Withdrawal
Initial Visit ☐☐	After Visit ☐☐

9. IF NONE AT THE END OF THIS VISIT GIVE REASON

IF PREGNANT:

- ☐ 1. Planned
- ☐ 7. Unplanned

- ☐ 2. Seeking Pregnancy
- ☐ 3. Other Reason
- ☐ 4. Infertility
- ☐ 5. Other Medical Reason
- ☐ 6. Relying on Partner

10. PROVIDERS OF MEDICAL/COUNSELING SERVICES

- ☐ 1. Physician ____
- ☐ 2. Midlevel Clinician ____
- ☐ 3. RN
- ☐ 4. LPN
- ☐ 5. Health Educator/Nutritionist
- ☐ 6. Lab Tech
- ☐ 7. Medical Assistant

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. Syphilis 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
- ☐ 42. Pap Smear
- ☐ 40. Lipid Profile
- ☐ 41. Metabolic Panel
- ☐ 43. Ph Test
- ☐ 44. Neg. Preg Test
- ☐ 45. Pos. Preg Test
- ☐ 46. Repeat Pap
- ☐ 47. RPR/VDRL
- ☐ 48. Stool Occult
- ☐ 50. TSH/T4
- ☐ 51. Urinalysis
- ☐ 52. Wet Mount

13. CHLAMYDIA

Reason for Visit

- ☐ 1. Symptomatic
- ☐ 3. Exposed to STD in Past 60 days
- ☐ 4. IUD Insertion
- ☐ 5. Preg Test
- ☐ 6. Patient Request
- ☐ 7. Client Meets Screening
- ☐ 8. Rescreen Prev Pos > 3 Mon.

Risk History

- ☐ 1. > 1 partner in past 60 days
- ☐ 2. New partner in past 60 days
- ☐ 3. History of STDs
- ☐ 4. No Risk History
- ☐ 5. MSM
- ☐ 6. Infrequent Condom Use

Treated Presumptively ☐ 1. Yes ☐ 2. No

Specimen Source

- ☐ 1. Cervical
- ☐ 2. Urethral
- ☐ 3. Vaginal
- ☐ 4. Urine
- ☐ 5. Pharyngeal
- ☐ 6. Rectal

14. COUNSELING SERVICES PROVIDED

- ☐ 61. ABC
- ☐ 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
- ☐ 88. PHQ-2
- ☐ 89. PHQ-9
- ☐ 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 Cessation
- ☐ 87. Genital Awareness
- ☐ 90. Reprod Life Plan

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. Physician Counseled
  - ☐ 24. None Warranted (PHQ-2 or 9)
  - ☐ 25. Client Declined
- ☐ 08. Nutritional Services
- ☐ 09. OPOP
- ☐ 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