

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 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

COMPLETE AT EACH VISIT

4. VISIT DATE _____ - 20____

5. PRIMARY SOURCE OF PAYMENT (check one)

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

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

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: 2. Seeking Pregnancy 4. Infertility
1. Planned 3. Not Currently Sexually Active 6. Other
7. Unplanned

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

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

12. LAB SERVICES PROVIDED

- | | | |
|---|--|---|
| <input type="checkbox"/> 30. Blood Glucose | <input type="checkbox"/> 38. HIV Test | <input type="checkbox"/> 46. Repeat Pap |
| <input type="checkbox"/> 31. CBC | <input type="checkbox"/> 39. HPV Typing | <input type="checkbox"/> 47. RPR/VDRL |
| <input type="checkbox"/> 32. Chlamydia Test | <input type="checkbox"/> 42. Pap Smear | <input type="checkbox"/> 48. Stool Occult |
| <input type="checkbox"/> 33. Gonorrhea Test | <input type="checkbox"/> 40. Lipid Profile | <input type="checkbox"/> 50. TSH/T4 |
| <input type="checkbox"/> 34. Hemoglobin | <input type="checkbox"/> 41. Metabolic Panel | <input type="checkbox"/> 51. Urinalysis |
| <input type="checkbox"/> 35. Hepatitis B | <input type="checkbox"/> 43. Ph Test | <input type="checkbox"/> 52. Wet Mount |
| <input type="checkbox"/> 36. Hepatitis C | <input type="checkbox"/> 44. Neg. Preg Test | |
| <input type="checkbox"/> 37. Herpes Test | <input type="checkbox"/> 45. Pos. Preg Test | |

13. CHLAMYDIA

Reason for Visit

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

Risk History

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

Treated Presumptively 1. Yes 2. No

Specimen Source

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

14. COUNSELING SERVICES PROVIDED

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

15. REFERRED ELSEWHERE (check all applicable)

- | | |
|--|---|
| <input type="checkbox"/> 01. Abnormal Pap | <input type="checkbox"/> 08. Nutritional Services |
| <input type="checkbox"/> 02. Breast Concerns | <input type="checkbox"/> 09. OPOP |
| <input type="checkbox"/> 03. Domestic Violence | <input type="checkbox"/> 10. Other - Medical |
| <input type="checkbox"/> 04. FAM/LAM | <input type="checkbox"/> 11. Positive Pregnancy |
| <input type="checkbox"/> 05. HIV Services/Screening | <input type="checkbox"/> 12. Rape Crisis/Abuse |
| <input type="checkbox"/> 06. Infertility | <input type="checkbox"/> 13. Social Services |
| <input type="checkbox"/> 07. Mental Health | <input type="checkbox"/> 14. Sterilization |
| <input type="checkbox"/> 19. Nat Lifeline (fax) | <input type="checkbox"/> 15. Substance Abuse |
| <input type="checkbox"/> 20. Priv. Counselor | <input type="checkbox"/> 16. Tobacco Cessation |
| <input type="checkbox"/> 21. Human Svcs. Center | <input type="checkbox"/> 17. WIC |
| <input type="checkbox"/> 22. Taken to Hospital | <input type="checkbox"/> 18. Women's Way |
| <input type="checkbox"/> 23. Physician Counseled | |
| <input type="checkbox"/> 24. None Warranted (PHQ-2 or 9) | |
| <input type="checkbox"/> 25. Client Declined | |