

NORTH DAKOTA CLINIC VISIT RECORD

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

CLINIC NO. _____

CLIENT NUMBER _____ DATE OF BIRTH _____ - 1 9 _____ GENDER: F M CONTACT STATUS _____

YEARS OF EDUCATION _____ ANNUAL INCOME _____ HOUSEHOLD SIZE _____ ZIP _____

TOBACCO USER Y N

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 _____ - 2 0 _____

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 Covering all or some Family Planning
 3. Private Health Insurance Covering no Family Planning
 4. Private Health Insurance unknown for Family Planning
 5. Uninsured
 6. Unknown

7. PURPOSE OF VISIT (check one)
 1. Initial Comprehensive 6. Method Check/Depo
 2. Annual Comprehensive 7. Education/Counseling Only
 3. Medical Visit 8. Pregnancy Test Only
 4. Problem Re-Visit 9. Supply Visit
 5. STD/Infection Check

8. CONTRACEPTIVE METHOD (Complete before and after blocks)

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

Initial Visit After Visit

9. IF NONE AT THE END OF THIS VISIT GIVE REASON
 1. Pregnant 4. Infertility
 2. Seeking Pregnancy 5. Other Medical Reason
 3. Other Reason 6. Relying on Partner Method

10. PROVIDERS OF MEDICAL/COUNSELING SERVICES
 1. Physician _____ 5. Health Educator/Nutritionist
 2. Midlevel Clinician _____ 6. Lab Tech
 3. RN 7. Medical Assistant
 4. LPN

VISIT CODES _____

NEXT EXAM DATE _____

11. MEDICAL SERVICES PROVIDED

<input type="checkbox"/> 01. BV Tx	<input type="checkbox"/> 11. Diaphragm Fit/Chk	<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. Cerv. 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. Rx Change
<input type="checkbox"/> 07. Colposcopy	<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. Cryotherapy	<input type="checkbox"/> 19. IUD Insertion	
<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"/> 40. Lipid Profile	<input type="checkbox"/> 48. Stool Occult
<input type="checkbox"/> 33. Gonorrhea Test	<input type="checkbox"/> 41. Metabolic Panel	<input type="checkbox"/> 49. Trichomoniasis
<input type="checkbox"/> 34. Hemoglobin	<input type="checkbox"/> 42. Pap Smear	<input type="checkbox"/> 50. TSH/T4
<input type="checkbox"/> 35. Hepatitis B	<input type="checkbox"/> 43. Ph Test	<input type="checkbox"/> 51. Urinalysis
<input type="checkbox"/> 36. Hepatitis C	<input type="checkbox"/> 44. Neg. Preg Test	<input type="checkbox"/> 52. Wet Mount
<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

Clinical Signs
 1. Cervical Friability 3. PID 5. None
 2. Mucopus 4. Urethritis

Risk History
 1. > 1 partner in past 60 days 3. + Chlamydia in past year
 2. New partner in past 60 days 4. No Risk History

Treated Presumptively 1. Yes 2. No

Test Type 03. DFA 17.1 TMP/GP/Aptima Combo

Specimen Source
 0. Other 3. Vaginal 5. Pharyngeal
 1. Cervical 4. Urine 6. Rectal
 2. Urethral

14. COUNSELING SERVICES PROVIDED

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

15. REFERRED ELSEWHERE (check all applicable)

<input type="checkbox"/> 01. Abnormal Pap	<input type="checkbox"/> 10. Other - Medical
<input type="checkbox"/> 02. Breast Concerns	<input type="checkbox"/> 11. Positive Pregnancy
<input type="checkbox"/> 03. Domestic Violence	<input type="checkbox"/> 12. Rape Crisis/Abuse
<input type="checkbox"/> 04. FAM	<input type="checkbox"/> 13. Social Services
<input type="checkbox"/> 05. HIV Services/Screening	<input type="checkbox"/> 14. Sterilization
<input type="checkbox"/> 06. Infertility	<input type="checkbox"/> 15. Substance Abuse
<input type="checkbox"/> 07. Mental Health	<input type="checkbox"/> 16. Tobacco Cessation
<input type="checkbox"/> 08. Nutritional Services	<input type="checkbox"/> 17. WIC
<input type="checkbox"/> 09. OPOP	<input type="checkbox"/> 18. Women's Way