SIDE A **FAMILY PLANNING (FP) FORM 1** ver. 3.0

FAMILY PLANNING CLIENT ASSESSMENT RECORD

Instructions for Physicians, Nurses and Midwives: ***Make sure that the client is not pregnant by using the questions listed in SIDE B.*** *Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation*

CLIENT ID: _____

PHILHEALTH NO.: _____

NHTS?: ☐Yes ☒No **Pantawid Pamilya Pilipino Program(4Ps):** ☐Yes ☒No

NAME OF CLIENT: WATSON (Last Name) EMMA (Given Name) P. (MI) 05/25/1995 (Date of Birth) 18 (Age) HIGHSCHOOL GRADUATE (Educ. Attain.) HOUSEWIFE (Occupation)

ADDRESS: WIWIW (No.) NOPE (Street) OKIE (Barangay) GORA (Municipality/City) 3543543 (Province) --SELECT-- (Contact Number) --SELECT-- (Civil Status) _____ (Religion)

NAME OF SPOUSE: _____ (Last Name) _____ (Given Name) _____ (MI) __/__/____ (Date of Birth) _____ (Age) _____ (Occupation)

NO. OF LIVING CHILDREN: 3 **PLAN TO HAVE MORE CHILDREN?** ☐ Yes ☒ No **AVERAGE MONTHLY INCOME:** _____

Type of Client

☐ New Acceptor — Reason for FP: ☐ spacing ☐ limiting others_____

☐ Current User

☐ Changing Method — Reason: ☐ medical condition side-effects _____

☐ Changing Clinic

☐ Dropout/ Restart

Method currently used (for Changing Method):

☐ COC ☐ IUD ☐ BOM/CMM ☐ LAM

☐ POP ☐ Interval ☐ BBT others

☐ Injectable ☐ Post-Partum ☐ STM specify: _____

☐ Implant ☐ Condom ☐ SDM

I. MEDICAL HISTORY

Does the client have any of the following?

▪ severe headaches / migraine	☐Yes	☒No
▪ history of stroke / heart attack / hypertension	☐Yes	☒No
▪ non-traumatic hematoma / frequent bruising or gum bleeding	☐Yes	☒No
▪ current or history of breast cancer / breast mass	☐Yes	☒No
▪ severe chest pain	☐Yes	☒No
▪ cough for more than 14 days	☐Yes	☒No
▪ jaundice	☐Yes	☒No
▪ unexplained vaginal bleeding	☐Yes	☒No
▪ abnormal vaginal discharge	☐Yes	☒No
▪ intake of phenobarbital (anti-seizure) or rifampicin (anti-TB)	☐Yes	☒No
▪ Is the client a SMOKER?	☐Yes	☒No
▪ With Disability? (if YES please specify: _____)		

II. OBSTETRICAL HISTORY

Number of pregnancies: G_____ P _____

0 Full term 0 Premature

0 Abortion 0 Living children

Date of last delivery 01/01/2000

Type of last delivery ☐Vaginal ☐Cesarean Section

Last menstrual period 01/01/2000

Previous menstrual period 01/01/2000

Menstrual flow :

☐scanty (1-2 pads per day)

☐moderate (3-5 pads per day)

☐heavy (>5 per pads day)

☐ Dysmenorrhea

☐ Hydatidiform mole (within the last 12 months)

☐ History of ectopic pregnancy

III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS

Does the client or the client's partner have any of the following?

▪ abnormal discharge from the genital area	☐Yes	☒No
if "YES" please indicate if from: ☐Vagina ☐Penis		
▪ sores or ulcers in the genital area	☐Yes	☒No
▪ pain or burning sensation in the genital area	☐Yes	☒No
▪ history of treatment for sexually transmitted infections	☐Yes	☒No
▪ HIV / AIDS / Pelvic inflammatory disease	☐Yes	☒No

Implant = Progestin subdermal implant; IUD = Intrauterine device; BTL = Bilateral tubal ligation; NSV = No-scalpel vasectomy; COC = Combined oral contraceptives; POP = Progestin only pills; LAM = Lactational amenorrhea method; SDM = Standard days method; BBT = Basal body temperature; BOM = Billings ovulation method; CMM = Cervical mucus method; STM = Symptothermal method

IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

▪ unpleasant relationship with partner	☐Yes	☒No
▪ partner does not approve of the visit to FP clinic	☐Yes	☒No
▪ history of domestic violence or VAW	☐Yes	☒No

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs

Others (Specify: _____)

V. PHYSICAL EXAMINATION

Weight: 0.0 kg Blood pressure: 0/0 mmHg

Height: 0.0 m Pulse rate: 0 /min

SKIN:
☐ normal
☐ pale
☐ yellowish
☐ hematoma

EXTREMITIES
☐ normal
☐ edema
☐ varicosities

CONJUNCTIVA:
☐ normal
☐ pale
☐ yellowish

PELVIC EXAMINATION
(For IUD Acceptors)
☐ normal
☐ mass
☐ abnormal discharge
☐ cervical abnormalities
☐ warts
☐ polyp or cyst
☐ inflammation or erosion
☐ bloody discharge

NECK:
☐ normal
☐ neck mass
☐ enlarged lymph nodes

BREAST:
☐ normal
☐ mass
☐ nipple discharge

☐ cervical consistency ☐ firm ☐ soft
☐ cervical tenderness
☐ adnexal mass / tenderness

ABDOMEN
☐ normal
☐ abdominal mass
☐ varicosities

☐ uterine position:
☐ mid
☐ anteflexed
☐ retroflexed

☐ uterine depth: 0 cm

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the Injectable, Pills method.

_____ 2024-01-21

Client Signature Date

For WRA below 18 yrs. Old:

I hereby consent EMMA P. WATSON to accept the Family Planning method.

_____ _____

Parent/Guardian Signature Date

SIDE B **FP FORM 1**

FAMILY PLANNING CLIENT ASSESSMENT RECORD

DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (Medical observation, complaints/ complication, service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	NAME AND SIGNATURE OF SERVICE PROVIDER	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)

How to be Reasonably Sure a Client is Not Pregnant

1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then? ☐ Yes ☐ No
2. Have you abstained from sexual intercourse since your last menstrual period or delivery? ☐ Yes ☐ No
3. Have you had a baby in the last four (4) weeks? ☐ Yes ☐ No
4. Did your last menstrual period start within the past seven (7) days? ☐ Yes ☐ No
5. Have you had a miscarriage or abortion in the last seven (7) days? ☐ Yes ☐ No
6. Have you been using a reliable contraceptive method consistently and correctly? ☐ Yes ☐ No

- If the client answered **YES** to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.
- If the client answered **NO** to all of the questions, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.