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: 2

PHILHEALTH NO.: 123456789098

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

NAME OF CLIENT: ESCALANTE, (Last Name) INES (Given Name) B. (MI) 01 / 01 / 1996 (Date of Birth) 30 (Age) BACHELOR'S DEGREE (Educ. Attain.) HOUSEWIFE (Occupation)

ADDRESS: STREET ROSE, PAJAC, LAPU-LAPU CITY, CEBU (No. Street Barangay Municipality/City Province) 5435 (Contact Number) MARRIED (Civil Status) ROMAN CATHOLIC (Religion)

NAME OF SPOUSE: ESCALANTE, (Last Name) CARCEL (Given Name) H. (MI) 05 / 01 / 1993 (Date of Birth) 33 (Age) KNIGHT (Occupation)

NO. OF LIVING CHILDREN: 2 **PLAN TO HAVE MORE CHILDREN?** ☒ Yes ☐ No **AVERAGE MONTHLY INCOME:** 30.000

Type of Client

☐ New Acceptor
☒ Current User
☒ Changing Method
☐ Changing Clinic
☐ Dropout/ Restart

Reason for FP: ☐ spacing ☐ limiting others_____
Reason: ☒ medical condition side-effects _____

Method currently used (for Changing Method):
☐ COC ☐ IUD ☐ BOM/CMM ☐ LAM
☐ POP ☐ Interval ☐ BBT others
☐ Injectable ☐ Post-Partum ☐ STM specify: NOL
☐ 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 _____
2 Full term 0 Premature
0 Abortion 2 Living children
Date of last delivery 07 / 01 / 2000
Type of last delivery ☐Vaginal ☒Cesarean Section
Last menstrual period 01 / 12 / 2024
Previous menstrual period 11 / 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: 61.5 kg
Height: 100.99 m
Blood pressure: 120/18 mmHg
Pulse rate: 50 /min

SKIN:
☐ normal
☒ pale
☐ yellowish
☐ hematoma

CONJUNCTIVA:
☒ normal
☐ pale
☐ yellowish

NECK:
☒ normal
☐ neck mass
☐ enlarged lymph nodes

BREAST:
☒ normal
☐ mass
☐ nipple discharge

ABDOMEN
☒ normal
☐ abdominal mass
☐ varicosities

EXTREMITIES
☒ normal
☐ edema
☐ varicosities

PELVIC EXAMINATION
(For IUD Acceptors)
☒ normal
☐ mass
☐ abnormal discharge
☐ cervical abnormalities
☐ warts
☐ polyp or cyst
☐ inflammation or erosion
☐ bloody discharge
☒ cervical consistency
☐ firm ☒ soft
☐ cervical tenderness
☐ adnexal mass / tenderness
☒ 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 Counseling, IUD, Condom, Pills method.

_____ 2025-02-01
Client Signature Date

For WRA below 18 yrs. Old:
I hereby consent _____ 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)
2025-05-05	Wala ray problema.	Pills	Monkey, Luffydasda	2025-05-10
2025-05-05	Wala ray problema.	Condom	Nico, Robin	2025-05-10

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.