

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: _____

Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation

ADDRESS: _____

No. Street Barangay Municipality/City Province Contact Number Civil Status Religion

NAME OF SPOUSE: _____

Last Name Given Name MI Date of Birth Age Occupation

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

Type of Client

☐ New AcceptorReason for FP: ☐ spacing ☐ limiting others _____

Method currently used (for Changing Method):

☐ Current User☐ COC ☐ IUD ☐ BOM/CMM ☐ LAM☐ Changing MethodReason: ☐ medical condition ☐ side-effects _____☐ POP ☐ Interval ☐ BBT ☐ others☐ Changing Clinic☐ Injectable ☐ Post-Partum ☐ STM specify: _____☐ Dropout/ Restart☐ 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? ☐ Yes ☐ No

(if YES please specify: _____)

II. OBSTETRICAL HISTORY

Number of pregnancies: G _____ P _____

_____ Full term _____ Premature

_____ Abortion _____ Living children

Date of last delivery ____/____/____

Type of last delivery ☐ Vaginal ☐ Cesarean Section

Last menstrual period ____/____/____

Previous menstrual period ____/____/____

Menstrual flow :

☐ scanty (1-2 pads per day)☐ moderate (3-5 pads per day)☐ heavy (>5 pads per 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

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: _____ kg

Blood pressure: _____ mmHg

Height: _____ m

Pulse rate: _____ /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

NECK:

- ☐ normal
- ☐ neck mass
- ☐ enlarged lymph nodes

- ☐ warts
- ☐ polyp or cyst
- ☐ inflammation or erosion
- ☐ bloody discharge

BREAST:

- ☐ normal
- ☐ mass
- ☐ nipple discharge

- ☐ cervical consistency
- ☐ firm ☐ soft

ABDOMEN

- ☐ normal
- ☐ abdominal mass
- ☐ varicosities

- ☐ adnexal mass / tenderness
- ☐ uterine position: ☐ mid ☐ anteфлекed ☐ retroфлекed
- ☐ uterine depth: _____ 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 _____ method.

Client Signature _____

Date _____

For WRA below 18 yrs. Old:

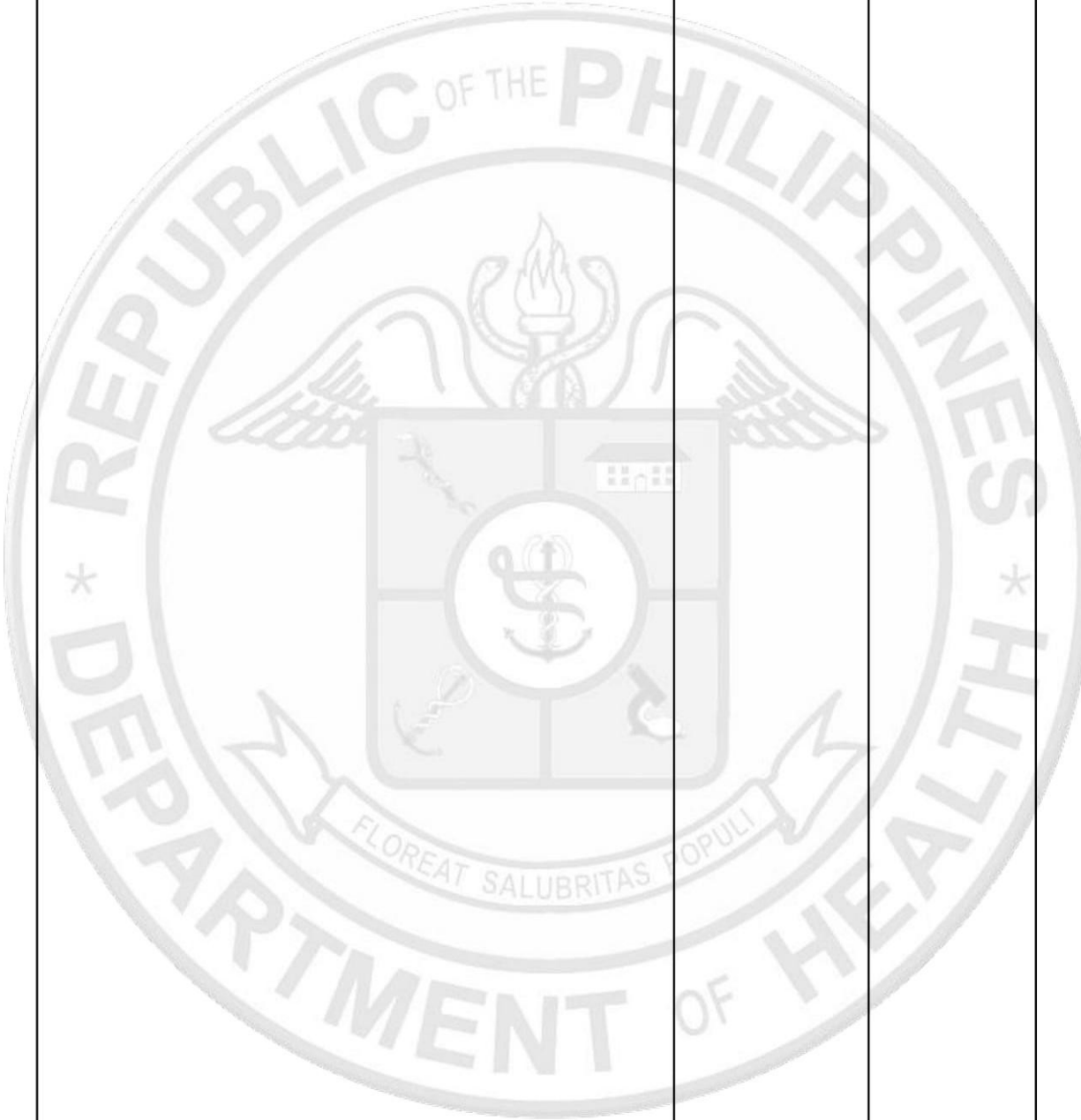
I hereby consent _____ to accept the Family Planning method.

Parent/Guardian Signature _____

Date _____

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

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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.