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: _____ / / _____ _____ _____
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 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_____

_____ 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 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: _____ kg Blood pressure: _____ mmHg

Height: _____ m Pulse rate: _____ /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: _____ 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

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.