Southern Health Santé Sud

Office Use Only
Client ID Confirmed YES ☐ NO ☐
Use CARE ☐ YES ☐ NO

REPRODUCTIVE HEALTH RECORD

Legal Name:	**Preferred Name:**	**Date of Birth:**
MHSC #:	**PHIN:**	
Address:	**Phone Number(s):**	

Health History

New Client ☐ **Existing Client** ☐ If existing client, skip to Follow Up section.

Reason for visit: _____

Discuss client/provider responsibility Yes ☐ No ☐

Discuss Confidentiality Yes ☐ No ☐

Mature Minor Form Yes ☐ No ☐ NA ☐

Parent aware of sexual activity/contraception: Yes ☐ No ☐ NA ☐

Comments: _____

Health History Form completed: Yes ☐ No ☐

Contraindications to contraception: Yes ☐ No ☐

LNMP: _____

Comments: _____

Substance use: (tobacco, alcohol, cannabis, other?)
Yes ☐ No ☐
If yes, amount: _____

Comments: _____

See Health hx ☐

Immunizations up to date: Yes ☐ No ☐

Comments: _____

_____

_____

_____

_____

Follow Up

Questions/Concerns: _____

Changes to Health History: Yes ☐ No ☐

Comments: _____

Changes to menses since last visit: Yes ☐ No ☐

☐ lighter ☐ heavier ☐ shorter ☐ longer ☐ other

LNMP: _____

Bleeding/spotting: Yes ☐ No ☐

Changes since last visit:

☐ headaches ☐ breasts ☐ vision ☐ weight
☐ mood ☐ discharge ☐ rash ☐ dysuria

☐ other _____

Comments:_____

_____

_____

Substance use: (tobacco, alcohol, cannabis, other?)
Yes ☐ No ☐
If yes, amount: _____

Comments: _____

See Health hx ☐

Immunizations up to date: Yes ☐ No ☐

Comments:_____

_____

_____

_____

_____

_____

Sexual History **See Health hx ☐**

Are you sexually active at present: Yes ☐ No ☐
Comments: _____

# of sexual partners/changes in sexual partners since last visit:
_____

Gender(s): _____

Practices: ☐ Oral ☐ Anal ☐ Vaginal

What body parts or objects go into you?_____
_____

What body parts or objects do you put into your partner(s)?_____
_____

Consistent and correct condom use: Yes ☐ No ☐
Comments: _____

Condoms ever slipped or broken: Yes ☐ No ☐
Comments: _____

Physical pain or bleeding during or after sex: Yes ☐ No ☐
Comments: _____

Emergency Contraception since last visit: Yes ☐ No ☐
Comments: _____

Are you satisfied with your sexual relationship? Yes ☐ No ☐

Do you have stress about gender identity or sexual orientation/attraction? Yes ☐ No ☐
Date: _____
Comments: _____
_____

Physical Exam

BP: _____

STI swabs/urine done: Yes ☐ No ☐
Comments: _____

Pregnancy Test: Pos ☐ Neg ☐ NA ☐

Pap Test
Date of last pap test: _____ NA ☐ Abnormal ☐

Comments: _____
_____
_____

Contraceptive Option

Able to purchase contraception supplies: Yes ☐ No ☐
Comments: _____

Explore with client ability to plan/budget for Contraception: Yes ☐ No ☐

Prescriber name: _____

Name of Contraceptive: _____

Amount given: _____

Lot #: _____ Expiry date: _____

Amount left on prescription: _____

(Depo) Site/route: _____ Next due (range): _____

Next Appointment: _____

Condoms offered: Yes ☐ No ☐
Condoms taken: Yes ☐ No ☐

Next Appointment: _____

Teaching

Check all that apply:

☐ Instructed how to use contraception
- ☐ Advised re: risks/warnings
- ☐ Reviewed potential adverse effects
- ☐ Reviewed missed doses

☐ Info re: emergency contraception
☐ STI Education
☐ Nutrition education
☐ Substance Use education
☐ Depo clients: Calcium/wt bearing exercise
☐ PAP guidelines
☐ HPV
☐ Herpes
☐ Community Resources
☐ Harm Reduction
☐ Healthy Relationships
☐ Lactational Amenorrhea Method (LAM)
☐ Other_____

AdditionalNotes:_____
_____

Date: _____ **Signature: _____**