

# NORTH DAKOTA CLINIC VISIT RECORD

CLINIC # \_\_\_\_\_ CLIENT # \_\_\_\_\_ D.O.B. \_\_\_\_\_ GENDER: F M ZIP \_\_\_\_\_

ANNUAL INCOME \_\_\_\_\_ HOUSEHOLD SIZE \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ HEIGHT (inches) \_\_\_\_\_ WEIGHT (pounds) \_\_\_\_\_

TOBACCO STATUS (check one):

- ☐ 1. Current Every Day    ☐ 3. Former  
☐ 2. Current Some Day    ☐ 4. Never

RACE (check all that apply)

- ☐ 1. White    ☐ 4. Asian  
☐ 2. Black or African American    ☐ 5. Pacific Is./Hawaiian  
☐ 3. Am. Ind./Alaskan    ☐ 6. Unknown/Unreported

LIMITED ENGLISH PROFICIENCY ☐ Y ☐ N

HISPANIC ☐ Y ☐ N ☐ Unknown/Not Reported

4. VISIT DATE \_\_\_\_\_ 20\_\_\_\_

5. PRIMARY SOURCE OF PAYMENT (check one)

- ☐ 1. No Fee    ☐ 5. Private Insurance  
☐ 2. Partial Fee    ☐ 6. Other Govt. Ins. (Military, VA)  
☐ 3. Full Fee    ☐ 7. Medicare  
☐ 4. Medicaid (Traditional or Expansion)    ☐ 8. Women's Way

6. CLIENT INSURANCE STATUS (check one)

- ☐ 1. Medicaid (Traditional)    ☐ 5. Uninsured  
☐ 3. Medicaid (Expansion)    ☐ 7. Other Govt. Ins. (Military, VA)  
☐ 2. Private Health Insurance    ☐ 8. Medicare  
☐ 4. Women's Way

7. PURPOSE OF VISIT (check one)

- ☐ 1. Preventive Health Visit (New Client)    ☐ 5. STD Screening/Tx  
☐ 2. Preventive Health Visit (Established Client)    ☐ 6. Contraceptive Surveillance  
☐ 3. Medical Visit    ☐ 7. Education/Counseling  
☐ 4. Problem Visit    ☐ 8. Pregnancy Test  
☐    ☐ 9. Supply Visit

16. TELEMEDICINE ENCOUNTER? ☐ Y ☐ N

8. PRIMARY METHOD (Complete before and after blocks)

- |                            |                         |
|----------------------------|-------------------------|
| 01. Sterile Male           | 09. Spermicide          |
| 02. Sterile Female         | 10. Diaphragm           |
| 03. Orals - Combined       | 11. Injectables         |
| 23. Orals - Progestin Only | 12. Contraceptive Patch |
| 04. IUD/Unspecified        | 13. Vaginal Ring        |
| 21. IUD w/Progestin        | 14. Sponge              |
| 22. IUD Copper             | 15. Withdrawal          |
| 05. FAM                    | 17. EC                  |
| 24. LAM                    | 18. Cervical Cap        |
| 06. Implantable Rod        | 19. None                |
| 07. Condom (male)          | 20. Decline to Answer   |
| 08. Condom (female)        |                         |

Before Visit ☐ After Visit ☐

9. IF NO METHOD GIVE REASON

- ☐ 1. Abstinence    ☐ 4. Infertility  
☐ 2. Seeking Pregnancy    ☐ 6. Other  
☐ 3. Same Sex Partner

Before Visit ☐ After Visit ☐

17. HOW CONTRACEPTIVE METHOD WAS PROVIDED:

- ☐ 1. Provided on site    ☐ 4. Provided Elsewhere  
☐ 2. Referral    ☐ 5. N/A  
☐ 3. Prescription

18. PREGNANCY STATUS

- ☐ 1. Pregnant  
☐ 2. Not Pregnant  
☐ 3. Unknown

19. PREGNANCY INTENTION

- ☐ 1. Yes  
☐ 2. Okay either way  
☐ 3. No  
☐ 4. Unsure

10. PROVIDERS OF MEDICAL/COUNSELING SERVICES

- ☐ 1. Physician    ☐ 4. CNM  
☐ 2. Nurse Prac.    ☐ 5. PA  
☐ 3. RN    ☐ 6. Other (LPN, MA, etc.)

11. MEDICAL SERVICES PROVIDED

- |                                                |                                              |                                                   |
|------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> 01. Bv Tx             | <input type="checkbox"/> 11. Herpes Tx       | <input type="checkbox"/> 21. IUD Check            |
| <input type="checkbox"/> 02. Blood Pressure    | <input type="checkbox"/> 12. EC              | <input type="checkbox"/> 22. Medical Hx           |
| <input type="checkbox"/> 03. Candida Tx        | <input type="checkbox"/> 13. Gonorrhea Tx    | <input type="checkbox"/> 23. Molluscum Tx         |
| <input type="checkbox"/> 04. CBE               | <input type="checkbox"/> 14. Height/Weight   | <input type="checkbox"/> 24. Pelvic Exam          |
| <input type="checkbox"/> 05. Diaph/Cap Fit/Chk | <input type="checkbox"/> 15. HPV Tx          | <input type="checkbox"/> 25. Phys. Assess         |
| <input type="checkbox"/> 06. Chlamydia Tx      | <input type="checkbox"/> 16. HPV Vaccine     | <input type="checkbox"/> 26. Contraceptive Change |
| <input type="checkbox"/> 07. Colpo/Cryo        | <input type="checkbox"/> 17. Implant Insert  | <input type="checkbox"/> 27. Testicular Exam      |
| <input type="checkbox"/> 08. Contracep. Refill | <input type="checkbox"/> 18. Implant Removal | <input type="checkbox"/> 28. Trich. Tx            |
| <input type="checkbox"/> 09. Syphilis Tx       | <input type="checkbox"/> 19. IUD Insertion   | <input type="checkbox"/> 29. UTI Tx               |
| <input type="checkbox"/> 10. 3-Month Injection | <input type="checkbox"/> 20. IUD Removal     |                                                   |

12. LAB SERVICES PROVIDED

- |                                             |                                               |                                                   |
|---------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> 30. Blood Glucose  | <input type="checkbox"/> 39. HPV Typing       | <input type="checkbox"/> 48. Stool Occult         |
| <input type="checkbox"/> 31. CBC            | <input type="checkbox"/> 40. Lipid Profile    | <input type="checkbox"/> 49. Trich. Rapid         |
| <input type="checkbox"/> 32. Chlamydia Test | <input type="checkbox"/> 41. Metabolic Panel  | <input type="checkbox"/> 50. TSH/T4               |
| <input type="checkbox"/> 33. Gonorrhea Test | <input type="checkbox"/> 42. Pap Smear        | <input type="checkbox"/> 51. Urinalysis           |
| <input type="checkbox"/> 34. Hemoglobin     | <input type="checkbox"/> 43. Ph Test/Rapid BV | <input type="checkbox"/> 52. Wet Mount            |
| <input type="checkbox"/> 35. Hepatitis B    | <input type="checkbox"/> 44. Neg. Preg. Test  | <input type="checkbox"/> 53. Mycoplasma Genitalia |
| <input type="checkbox"/> 36. Hepatitis C    | <input type="checkbox"/> 45. Pos. Preg. Test  | <input type="checkbox"/> 54. Monkeypox Test       |
| <input type="checkbox"/> 37. Herpes Test    | <input type="checkbox"/> 46. Repeat Pap.      |                                                   |
| <input type="checkbox"/> 38. HIV Test       | <input type="checkbox"/> 47. Syphilis Test    |                                                   |

14. COUNSELING SERVICES PROVIDED

- |                                               |                                                |                                                 |
|-----------------------------------------------|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> 61. Safe Sex Edu.    | <input type="checkbox"/> 71. Immunizations     | <input type="checkbox"/> 81. Req. Adol. Counsel |
| <input type="checkbox"/> 62. Blood Pressure   | <input type="checkbox"/> 72. Infertility       | <input type="checkbox"/> 82. Breast Awareness   |
| <input type="checkbox"/> 63. Colorectal Scrn. | <input type="checkbox"/> 73. Male Exam         | <input type="checkbox"/> 83. Sterilization      |
| <input type="checkbox"/> 64. Contraception    | <input type="checkbox"/> 74. Mental Health     | <input type="checkbox"/> 84. Substance Abuse    |
| <input type="checkbox"/> 65. Domestic Viol.   | <input type="checkbox"/> 75. Nutrition         | <input type="checkbox"/> 85. STD Follow-Up      |
| <input type="checkbox"/> 66. Exercise         | <input type="checkbox"/> 76. Obesity           | <input type="checkbox"/> 86. Tobacco            |
| <input type="checkbox"/> 67. FAM/LAM          | <input type="checkbox"/> 77. Pap Follow-Up     | <input type="checkbox"/> 87. Genital Awareness  |
| <input type="checkbox"/> 68. Female Exam      | <input type="checkbox"/> 78. Preconception     | <input type="checkbox"/> 88. PHQ-2              |
| <input type="checkbox"/> 69. Genetic Counsel  | <input type="checkbox"/> 79. Pregnancy         | <input type="checkbox"/> 89. PHQ-9              |
| <input type="checkbox"/> 70. HIV              | <input type="checkbox"/> 80. Rape Crisis/Abuse | <input type="checkbox"/> 90. Reprod. Life Plan  |
|                                               |                                                | <input type="checkbox"/> 91. Achieve Pregnancy  |

15. REFERRED ELSEWHERE (check all applicable)

- |                                                          |                                                   |
|----------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> 01. Abnormal Pap                | <input type="checkbox"/> 08. Nutritional Services |
| <input type="checkbox"/> 02. Breast Concerns             | <input type="checkbox"/> 10. Other - Medical      |
| <input type="checkbox"/> 03. Domestic Violence           | <input type="checkbox"/> 11. Positive Pregnancy   |
| <input type="checkbox"/> 04. FAM/LAM                     | <input type="checkbox"/> 12. Rape Crisis/Abuse    |
| <input type="checkbox"/> 05. HIV Services/Screening      | <input type="checkbox"/> 13. Social Services      |
| <input type="checkbox"/> 06. Infertility                 | <input type="checkbox"/> 14. Sterilization        |
| <input type="checkbox"/> 07. Mental Health               | <input type="checkbox"/> 15. Substance Abuse      |
| <input type="checkbox"/> 19. Nat. Lifeline (fax)         | <input type="checkbox"/> 16. Tobacco Cessation    |
| <input type="checkbox"/> 20. Priv. Counselor             | <input type="checkbox"/> 17. WIC                  |
| <input type="checkbox"/> 21. Human Svcs. Center          | <input type="checkbox"/> 18. Women's Way          |
| <input type="checkbox"/> 22. Taken to Hospital           | <input type="checkbox"/> 26. Ryan White           |
| <input type="checkbox"/> 23. Provider Counseled          |                                                   |
| <input type="checkbox"/> 24. None Warranted (PHQ-2 or 9) |                                                   |
| <input type="checkbox"/> 25. Client Declined             |                                                   |

20. DO YOU WANT TO TALK ABOUT CONTRACEPTION OR PREGNANCY TODAY?

- ☐ 01. Yes - I want to talk about contraception.  
 No - I don't want to talk about contraception:  
☐ 02. I'm here for something else.  
☐ 03. This question doesn't apply to me.  
☐ 04. I prefer not to answer.  
☐ 05. I'm already using contraception.  
☐ 06. I'm unsure or don't want to use contraception.  
☐ 07. I'm hoping to become pregnant in the near future.