

SOUTHERN NEVADA HEALTH DISTRICT
CLIENT INFORMATION AND INFORMED CONSENT FORM

NAME OF SCHOOL IF YOU ARE A STUDENT _____

PLEASE SELECT **ALL** THAT APPLY AS TO HOW WE MAY CONTACT YOU

_____ CALL HOME _____ CALL WORK _____ CALL CELL _____

_____ CALL _____ LEAVE MESSAGE WITH _____ RELATIONSHIP _____

_____ MAIL (PLAIN ENVELOPE) _____ MAIL (RETURN ADDRESS)

MAILING ADDRESS, IF DIFFERENT FROM HOME ADDRESS _____

PLEASE LIST WHOM TO CONTACT IN CASE OF AN EMERGENCY
(PARENT OR GUARDIAN IF UNDER 18).

An emergency would be severe bleeding, unconsciousness, accident, or a condition requiring ambulance transport or hospitalization. Family Planning services **DO NOT** require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian. Please be advised, if you are under 18 years of age, that through our attempts to notify you of your results, a parent may become aware of your circumstances. Otherwise, no information about your care will be given to anyone without your knowledge and permission except as required by law.

EMERGENCY CONTACT _____ RELATIONSHIP _____

STREET ADDRESS _____ APARTMENT NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

PLACE OF EMPLOYMENT _____

HOME PHONE: _____ WORK PHONE _____ MESSAGE PHONE _____

INFORMED CONSENT FOR FAMILY PLANNING SERVICES/SEXUALLY TRANSMITTED INFECTION CLINIC

I, _____, do hereby give my consent to the medical staff of Southern Nevada Health District Family Planning Clinic and/or Sexually Transmitted Infection Clinic to examine, obtain necessary lab work, treat, and counsel me. I understand that there are certain hazards and risks connected with all forms of treatment and care and with this knowledge, I give my consent. I understand that if tests are taken for sexually transmitted diseases, reporting of positive results to public health agencies may be required by law. I understand that the clinic staff is required by law to report any claims of physical or sexual abuse.

I hereby certify that I have read and fully understand the above consent for treatment.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

Today's Date: REASON FOR VISIT: INITIAL EXAM		PREGNANCY HISTORY					INITIAL DATA BASE	
1a. Date of Last Period:		1d. How many Pregnancies?					NAME: _____	
1b. Age at 1 st Period:		1e. How many live births?					BIRTHDATE: _____	
1c. Age of 1 st Sex:		1f. How many abortions?					AGE: _____	
SUBJECTIVE DATA BASE		None	Oral	IUD	Diaph	Depo	Other	2b.currentmethod, how long used, problems/ failure
2a. Desired birth control method								
FAMILY HISTORY					N	Y	COMMENTS	
3a. Diabetes								
b. High Blood Pressure								
c. Anemia/Sickle Cell								
d. Breast Cancer								
e. Tay Sachs, Down's Syndrome								
f. Stroke or Heart Attack before age 40								
PATIENT HISTORY								
4a. Diabetes								
b. Blood Clots in arms, legs or chest								
c. Heart Problems/High Blood Pressure								
d. Anemia/Sickle Cell								
e. Headaches/Migraines								
f. Seizures								
g. Asthma, TB or Lung Problems								
h. Have you been treated by a Doctor for depression?								
i. Breast Mass or Discharge from Nipples								
5a. Vaginal infections or discharge at present								
b. Abdominal Pain								
c. Any abnormal Pap Smears or Female Problems								
d. Sexually transmitted diseases								
6a. How many days does your period last?								
b. Does your period come every month?								
c. Do you have excessive bleeding or pain ?								
d. Do you have bleeding between periods or after sex?								
e. Do you engage in Vaginal sex? _____ Oral sex ? _____ Rectal Sex? _____								
f. Number of sex partners in last year? _____ Number female _____ Number Male _____ Length of time with current partner? _____								
7. Do you have any allergies to medications?								
8. List any Surgery, Illness, or Hospitalizations.								
9. Kidney disease/Urinary Tract infection								
10. List any use of medication, street drugs, Cigarettes, or Alcohol.								
11. Do you have thyroid disease?								
12. Have you been immunized against measles?								
13. History of DES exposure?								
PSYCHOSOCIAL/DOMESTIC VIOLENCE								
14. Do you see a Doctor when you are ill?								
15. Is there anyone in your life who is trying to control your actions?								
16. Has anyone at home ever hit you or tried to injure you in any way?								
17. Are you in such a relationship now?								

SIGNATURE:

DATE: