



Student Health Centers

# PATIENT VISIT ASSESSMENT FORM

Name: \_\_\_\_\_ Date \_\_\_\_\_

Email address: \_\_\_\_\_ Phone # \_\_\_\_\_

Current Contraception Method: \_\_\_\_\_ First Day of Last Normal Menstrual Period: \_\_\_\_\_

### Reason for visit: (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> First exam ever   | <input type="checkbox"/> Implanon consultation or insertion (circle one)    | <input type="checkbox"/> Other problems/symptoms (please describe): _____ |
| <input type="checkbox"/> Pap Smear yearly exam                                   | <input type="checkbox"/> Breast problem                                     | _____   |
| <input type="checkbox"/> Repeat Pap Smear  | <input type="checkbox"/> Suspect pregnancy                                  | _____   |
| <input type="checkbox"/> Abnormal Pap smear                                      | <input type="checkbox"/> Urinary/bladder problem                            | _____   |
| <input type="checkbox"/> Birth Control refill or start (circle one)              | <input type="checkbox"/> Vaginal discharge                                  | _____   |
| <input type="checkbox"/> Depo injection-1 <sup>st</sup> or followup (circle one) | <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Foul odor | <input type="checkbox"/> Follow-up lab results _____                      |
| <input type="checkbox"/> Smoking cessation                                       | <input type="checkbox"/> Sexually transmitted infection                     | _____   |
| <input type="checkbox"/> Gardasil Vaccine  | <input type="checkbox"/> Contraception problem                              | _____   |
|  | <input type="checkbox"/> Colposcopy   | _____   |

- How long have you been sexually active with your present partner(s)? \_\_\_\_\_ Have you been screened for STDs since this partner?  Yes  No  Not sexually active
- When was your last sexual encounter? \_\_\_\_\_
- Has your health or your family's health changed since your last visit?  No  Yes  
(If yes, please state these health changes): \_\_\_\_\_
- Are you taking any new medications (prescriptions/antibiotics, etc.) since your last visit or within the last two weeks?  
 No  Yes (If yes, please list): \_\_\_\_\_
- Are you aware that you can obtain Hepatitis B vaccine and the HPV vaccine (Gardasil) at SHC?  No  Yes
- Did you know you can get Plan B (emergency contraception) without a prescription?  No  Yes
- Do you use condoms?  Every time  Sometimes  Never
- Do you smoke?  No  Yes If yes, how many cigarettes per day? \_\_\_\_\_
- How many alcohol beverages do you consume? # per day \_\_\_\_\_ # of days per \_\_\_\_/wk

### Lab Results

- ★ Annual/wellness exams are covered under the Tulane Student Health Service fee, *excluding* all lab work performed. There is a fee for all lab work done.
- ★ Lab tests done at the time of your visit may include: Pap smear, chlamydia, gonorrhea, microscopic examination of vaginal discharge, urinalysis, cultures, etc.
- ★ You will be notified of all abnormal lab results by phone or by mail (if we are unable to reach you by phone). If, AND ONLY IF, you have an (ASCUS) abnormal Pap smear result, a test for HPV (Human Papilloma Virus) will be done automatically on the Pap smear specimen. If the HPV test is done, is an additional charge of \$135 will be added to your account.

Please initial you are aware of the above charge. \_\_\_\_\_