

**1.1 COMPREHENSIVE FEMALE HEALTH HISTORY & PERIODIC PHYSICAL ASSESSMENT**

TITLE	DESCRIPTION
DEFINITION:	<p>Title X clinics <u>must</u> obtain and record a comprehensive health history in the client's medical record. The comprehensive health history <u>must</u> be collected at the initial visit and reviewed and updated annually. The comprehensive health history should be collected at the following visit types: Contraceptive services, basic infertility services, preconception health services, STD services, and related preventive health services. Any clinical staff (Clinical Assistant, Medical Assistant, LPN, RN, APRN, PA, or Physician) can obtain the health history. Appropriate clinic staff (Physician, APRN, PA, or RN) need to review the health history and make notation in the medical record regarding self-reported variants. The following are guidelines for the comprehensive health history and periodic health assessment. Guidelines should never be a substitute for sound clinical judgement.</p> <p>A physical assessment visit involves screening, evaluation &amp; counseling based on age, risk factors, desire for contraceptive, and other preventive health services as outlined by CDC Quality Family Planning (QFP) guidelines. These health services include contraceptive options, pregnancy testing &amp; counseling, achieving pregnancy, basic infertility, preconception health, breast and/or pelvic exam, &amp; STI screening. In addition, other preventive health services may be included. Although important in the context of primary care, these have no direct link to family planning services. Providers of family planning services should be trained and equipped to offer all family planning and related preventive health services for optimal care to clients. Regardless of whether a physical exam is performed, a woman should be seen face to face annually by a mid-level clinician or physician for well woman care.</p> <p>The decision of when to schedule examinations or laboratory testing must be made on an individual basis after review of the health history and counseling by the provider. Professional medical judgement based on the comprehensive health history, as well as professional medical society recommendations must be considered when determining what services, the client requires. It remains the responsibility of the medical provider to decide the individual client's need for services at every visit. Some clients will need no or few examinations or laboratory tests before starting a method of contraception. It is a goal of Title X to decrease unnecessary barriers to contraceptive access while maintaining safety to the client.</p>
SUBJECTIVE:	<p><b>Comprehensive history review should include:</b></p> <ol style="list-style-type: none"> <li>1. Date of birth.</li> <li>2. Reproductive Life Plan.</li> <li>3. Gynecologic history including diethylstilbestrol exposure (DES) if born prior to 1970.</li> <li>4. Pap history.</li> <li>5. Menstrual history.</li> <li>6. Contraceptive history.</li> <li>7. Obstetrical history.</li> <li>8. Allergies.</li> <li>9. Medications.</li> <li>10. Immunizations.</li> <li>11. Sexual Health Assessment.</li> <li>12. Past medical history including infectious or chronic health conditions.</li> <li>13. Review of systems should include:</li> </ol>

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	<ul style="list-style-type: none"> <li>a. Constitutional.</li> <li>b. Eyes, ears, nose, mouth, throat.</li> <li>c. Cardiovascular.</li> <li>d. Respiratory.</li> <li>e. Gastrointestinal.</li> <li>f. Genitourinary.</li> <li>g. Musculoskeletal.</li> <li>h. Skin.</li> <li>i. Endocrine.</li> <li>j. Psychological.</li> <li>k. Neurological.</li> <li>l. Hematological/Lymphatic.</li> </ul> <p>14. Hospitalizations, surgeries, injuries.</p> <p>15. Personal history (as appropriate):</p> <ul style="list-style-type: none"> <li>a. Behavioral risks (e.g. tobacco use, alcohol use, drug use (route of use), high risk behaviors.</li> <li>b. Psychosocial (e.g. sexual orientation/gender identity, bullying/cyber safety, peer/intimate relationships, self-mutilation, etc.).</li> <li>c. Intimate partner violence (IPV) and domestic violence (DV).</li> </ul> <p>16. Family history:</p> <ul style="list-style-type: none"> <li>a. Myocardial infarction, stroke, or thromboembolic disorder before age 50.</li> <li>b. Thyroid disorders.</li> <li>c. Genetic disorders. <ul style="list-style-type: none"> <li>i. Especially history suggestive of increased risk for diagnosis at an early age, bilateral breast cancer in one or more female family members, multiple cases of breast cancer in the family, both breast and ovarian cancer in the family, one or more family members with two primary cases of breast or ovarian cancer.</li> <li>ii. Chromosomal risk assessment, per ACOG guidelines.</li> </ul> </li> <li>d. Diabetes.</li> <li>e. High cholesterol.</li> </ul>
OBJECTIVE:	<p><b>Physical assessment must include:</b> BP must be done yearly (for CHCs and Preconception). For clients with abnormal BP, see <b>Elevated Blood Pressure-Prehypertension</b>.</p> <p><b>Physical assessment may include, but is not limited to:</b></p> <ul style="list-style-type: none"> <li>1. Height, weight, and BMI.</li> <li>2. General overall appearance of female clients.</li> <li>3. HEENT – eyes, ears, nose, mouth including gums, roof of mouth, tongue, pharynx, and neck (thyroid gland, lymph nodes).</li> <li>4. Skin – lesions, rashes, or any skin changes.</li> <li>5. Heart – RRR, any murmurs.</li> <li>6. Lungs – auscultate.</li> <li>7. Back – inspect &amp; palpate the spine, any deformities.</li> <li>8. Breast – inspection &amp; palpation, including axillae bilateral</li> </ul>

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	<table><tr><th colspan="4">Recommendation for Clinical Breast Examination</th></tr><tr><th>American College of Obstetricians and Gynecologist</th><th>U.S. Preventive Services</th><th>American Cancer Society</th><th>National Comprehensive Cancer Network</th></tr><tr><td>May be offered* every 1-3 years for women aged 25-39 years and annually for women 40 years and older.</td><td>Insufficient evidence to recommend for or against.</td><td>Does not recommend.</td><td>Recommend every 1-3 years for women aged 25-39. Recommend annually for women 40 years and older.</td></tr><tr><td colspan="4">*Offer in the context of a shared, informed decision-making approach that recognizes the uncertainty of additional benefits and harms of clinical breast examination beyond screening mammography.</td></tr></table> <p>9. Abdomen – bowel sounds, masses, tenderness, hepatosplenomegaly, or hernias.</p> <p>10. Extremities – assess for varicosities, pedal pulses, signs of phlebitis, or edema Evaluate range of motion (ROM).</p> <p>11. Pelvic exam – includes external inspection, vaginal assessment with speculum, and bimanual exam.</p> <p>a. Pelvic exams for all women should be performed when indicated by medical history or symptoms.</p> <p>b. Based on the current limited data on potential benefits and harms and expert opinion, the decision to perform a pelvic examination should be a shared decision between the patient and her gynecologic care provider.</p> <p>c. After reviewing risks and benefits, the pelvic examination also may be performed if a woman expresses a preference for the examination.</p> <p>12. Rectal exam – age ≥ 50 as indicated.</p> <p>a. Screening should begin earlier than age 50 if there is a personal or family history of colorectal cancer or polyps.</p>	Recommendation for Clinical Breast Examination				American College of Obstetricians and Gynecologist	U.S. Preventive Services	American Cancer Society	National Comprehensive Cancer Network	May be offered* every 1-3 years for women aged 25-39 years and annually for women 40 years and older.	Insufficient evidence to recommend for or against.	Does not recommend.	Recommend every 1-3 years for women aged 25-39. Recommend annually for women 40 years and older.	*Offer in the context of a shared, informed decision-making approach that recognizes the uncertainty of additional benefits and harms of clinical breast examination beyond screening mammography.			
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LABORATORY:	<p><b>May Include:</b></p> <p>1. Pap screening – see <b>Preventive Health Services for Women: Cervical Cytology Management</b> protocol.</p> <p>2. STI screening – per current CDC Sexually Transmitted Disease Guidelines.</p> <p>3. HIV screening – between age 13 and 64 at least once and if high risk history of STI at any age as indicated.</p> <p>4. Lipid screening – per USPSTF guidelines.</p> <p>5. Colorectal screening – per USPSTF guidelines.</p> <p>6. Diabetes screening – per USPSTF guidelines.</p> <p>7. Hepatitis C – should offer one-time screening for hepatitis C (HCV) infections for persons in the 1945-1965 birth cohorts or any person at high risk for infection and unaware of HCV status.</p> <p>8. Other lab tests as warranted:</p> <p>a. Pregnancy testing – urine/serum.</p> <p>b. Wet mount, KOH whiff test.</p> <p>c. Rubella Titer.</p> <p>d. TB testing.</p> <p>e. Urinalysis/culture as indicated.</p> <p>f. CBC.</p> <p>g. Herpes Simplex (HSV).</p> <p>h. Hepatitis B.</p> <p>i. Syphilis.</p>																

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ASSESSMENT:	Health screening female client. For a checklist of family planning and related preventive health services for women, see CDCs <i>Providing Quality Family Planning Services</i> , Page 22, Table 2.
PLAN/EDUCATION:	<ol style="list-style-type: none"> <li>1. Review with client any potential physical findings and/or laboratory results. The client <u>must</u> demonstrate clear understanding that they will be notified of abnormal Pap smear cytology and/or other abnormal test results.</li> <li>2. Counsel client on contraceptive options &amp; provide appropriate contraceptive method, including emergency contraceptive (EC) as indicated.</li> <li>3. Schedule appropriate referrals for any needed services not provided at clinic.</li> <li>4. Counsel clients regarding STI/HIV screening, and reduction including barrier methods and safer sex practices.</li> <li>5. Review immunization recommendations per CDC guidelines. Provide or recommend vaccines according to current CDC ACIP guidelines.</li> <li>6. Provide preconception health counseling if desires pregnancy.</li> <li>7. If client is seeking infertility evaluation, both partners should begin at the same time (<b>see Basic Infertility Services protocol</b>).</li> <li>8. Counsel and document if positive for any behavioral risk factors: <ol style="list-style-type: none"> <li>a. Obesity.</li> <li>b. Lifestyle changes.</li> <li>c. Diet.</li> <li>d. Exercise.</li> <li>e. Risks associated with obesity.</li> <li>f. Programs available for weight control.</li> <li>g. Montana Quit Line for tobacco cessation.</li> </ol> </li> <li>9. Document client verbalizes clear understanding of information and counseling provided.</li> <li>10. Advise the client to return at any time to discuss side effects or other problems, if she wants to change the method being used and/or when it is time to remove or replace the contraceptive method. A routine f/u visit may be required for a periodic physical assessment.</li> </ol>
REFERRAL TO MEDICAL PROVIDER:	<ol style="list-style-type: none"> <li>1. Any health services beyond the scope of Title X services or abnormal findings on physical exam are referred to PCP or specialty care as warranted. Whenever possible, clients should be given a choice of providers from which to select for referral services.</li> <li>2. Any psychological problems which need immediate assessment including social services, and victim services.</li> <li>3. Any infertility outside basic infertility services.</li> <li>4. Family history is associated with an increased risk for mutation in BRCA 1 or BRCA 2, colon cancer, melanoma for genetic counseling.</li> <li>5. Referral for all pregnant clients seeking prenatal care services.</li> <li>6. Mammogram (by referral) (<b>See Preventive Health Services for Women: Breast Imaging Guidelines</b>).</li> </ol>
REFERENCES:	<ol style="list-style-type: none"> <li>1. <a href="https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/The-Initial-Reproductive-Health-Visit">American College of Gynecology Committee Opinion #598: The Initial Reproductive Health Visit</a> (<a href="https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/The-Initial-Reproductive-Health-Visit">https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/The-Initial-Reproductive-Health-Visit</a>), May 2014 (Reaffirmed 2018).</li> <li>2. <a href="https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Well-Woman-Visit">American College of Gynecology Committee Opinion #755: Well Woman Visit</a> (<a href="https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Well-Woman-Visit">https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Well-Woman-Visit</a>).</li> </ol>

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	<p><i>on-Gynecologic-Practice/Well-Woman-Visit</i>), September 2018.</p> <ol style="list-style-type: none"> <li>3. <i>Oeffinger KC, Fontham ETH, Etzioni R, et al Breast Cancer Screening for Women at Average Risk 2015 Guideline Update from the American Cancer Society, JAMA 2015; 314(15): 1599-1614.</i></li> <li>4. <i>USPSTF Summary of Type 2 Diabetes screening recommendation, June 2008</i></li> <li>5. <i>Gavin, L., Moskosky, S., Carter, M., et al. <a href="#">Providing Quality Family Planning Services</a> Recommendations of CDC and the U.S. Office of Population Affairs. MMWR 2014;63 (No.RR-4). (<a href="http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf">http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf</a>).</i></li> <li>6. <a href="#">CDC Sexually Transmitted Diseases Treatment Guidelines</a> (<a href="https://www.cdc.gov/std/tg2015/tg-2015-print.pdf">https://www.cdc.gov/std/tg2015/tg-2015-print.pdf</a>) 2015.</li> <li>7. <a href="#">Centers for Disease Control Planning for Pregnancy</a> (<a href="https://www.cdc.gov/preconception/planning.html">https://www.cdc.gov/preconception/planning.html</a>).</li> <li>8. <a href="https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women">https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women</a> (<a href="https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women">https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women</a>), August 2011 (Reaffirmed 2017).</li> <li>9. <a href="#">American College of Gynecology Committee Opinion #754: The Utility of and Indications for Routine Pelvic Examination</a> (<a href="https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Utility-of-and-Indications-for-Routine-Pelvic-Examination">https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Utility-of-and-Indications-for-Routine-Pelvic-Examination</a>), September 2018.</li> </ol>