

MENSTRUAL HISTORY

First day of last normal period ____/____/____
How often do you get your period? Every ____ days How many days do you bleed? ____
Is your bleeding... light medium heavy
Age when your period began ____ Do you bleed between your period? Yes No
Unusual or missed periods in past year Yes No
Do you think you might be pregnant now? Yes No
Any other issues or problems you wish to discuss? _____

PREGNANCY HISTORY/PLAN

Total number of times pregnant ____ # of live births ____ # of stillborn ____
List month & year each pregnancy ended _____
Have you had unprotected sex since your last period? Yes No
of miscarriages ____ # of abortions ____
Types of delivery Vaginal Caesarean
Do you want to be pregnant now? Yes No
Do you know when in your menstrual cycle you are most likely to become pregnant? Yes No
Have you had problems getting pregnant? Yes No
Complications with pregnancy? Yes No
Have you ever had a tubal pregnancy? Yes No
Have you had a baby who weighed less than 5 1/2 pounds at birth? Yes No
Have you had preeclampsia/eclampsia (toxemia, high blood pressure)? Yes No
Have you had diabetes that started during pregnancy (gestational diabetes)? Yes No
Have you had a baby born with birth defects? If yes what kind? _____ Yes No
Tell us about any problems you have or had with your birth control _____
Do you plan on any (more) pregnancies? Yes No Undecided If yes, when _____

SEXUAL HISTORY

Are you currently sexually active? oral anal vaginal
Do you have pain or bleeding during or after sex? Yes No
Do you have any sores/rashes/burns? Yes No
Does your partner(s) have STD symptoms? Yes No
Has your partner(s) recently been treated for a STD Yes No
Has anyone ever forced you to do anything you didn't want to Yes No
Do you use a condom to protect yourself when sexually active Yes No
Your age at first time of intercourse (sex) _____

Do you douche? Occasionally Regularly Never
How many partners have you had in the last 90 days ____ lifetime ____
Have you ever had a STD? Yes No
If yes circle which: Gonorrhea, Chlamydia, Herpes, Syphilis, HPV/Warts
Would you like to be tested for HIV? Yes No
Is there anything you'd like to change about your sex life? _____

CONTRACEPTIVE HISTORY

What method of birth control are you using now? _____
Length of use ____ Problems if any ____
What methods of birth control have you used before? _____
What method would you like to use at this time? Pill Depo Provera
 Condoms Diaphragm Nuva Ring Patches
 Foam/Cream/Suppository Sterilization IUD Other _____

FOR STAFF USE ONLY: EDUCATION DOCUMENTATION

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|--|---|--|---|
| Patient Rights | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | STD's/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Reproductive anatomy/physiology | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | DES and its risks | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Breast and pelvic exam and lab | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Emergency Contraception | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| I have been offered condoms | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Importance of Rubella immunization | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Risks w/smoking & hormonal contraceptives | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Importance of folic acid to help prevent spine/brain defects | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Contraceptive methods overview (ben/side effects, use) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Parental involvement | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Adolescent Ed -> Sexual coercion | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |

I have been educated on the following topics that apply to me, and have had all my questions answered. I understand all of the information that has been discussed with me and have no questions at this time.

CLIENT SIGNATURE (or legal representative) _____ Date _____

PROVIDER SIGNATURE _____ Date _____

MEDICAL UPDATES

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.
Date of 2nd Year Review _____ No Exceptions List Exceptions _____

CLIENT SIGNATURE (or legal representative) _____ Date _____

PROVIDER SIGNATURE _____ Date _____