

Chart # _____

FAMILY REPRODUCTIVE HEALTH SERVICES
Chadron, NE 69337 Phone: 308-432-8979

NEW CONTRACEPTIVE METHOD FOLLOW-UP

Client Name _____

Date _____ Wt _____ Blood pressure _____ Age _____

Pill Name of your pill _____ Depo Patch Nuva Ring Other _____

First Day of Last Period _____

Please check if you have had any of the following since beginning your birth control:

- | | |
|--|--|
| <input type="checkbox"/> Nausea (sick to your stomach) | <input type="checkbox"/> Spotting or bleeding between periods |
| <input type="checkbox"/> Sudden or severe headaches | <input type="checkbox"/> Unusual vaginal discharge |
| <input type="checkbox"/> Unexplained dizziness | <input type="checkbox"/> Fluid Retention (swelling of ankles, wrists or fingers) |
| <input type="checkbox"/> Vision or speech problems | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Chest pain or trouble breathing | <input type="checkbox"/> Trouble with contacts |
| <input type="checkbox"/> Pain, weakness or numbness in arms/legs | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Lump, swelling or redness in legs | <input type="checkbox"/> Kin changes or discolorations |
| <input type="checkbox"/> Depression or irritability | <input type="checkbox"/> Abdominal (stomach) pain |

1. Have you had any changes in your periods? YES NO If yes, describe:

2. Have you had any symptoms of pregnancy? YES NO If yes, describe:

3. Are there problems or concerns you would like to discuss?

4. What would you do if you missed your pill or shot or forgot a new patch or ring?

5. Do you take your pills or put on/in your patch/vaginal ring consistently (same time each day/week?) YES NO
Always tell your provider you are on birth control pills when s/he prescribes antibiotics. Use a back-up method (foam/condoms) along with your current birth control)

Client Signature _____ Date _____

Staff Signature _____ Date _____

Staff Documentation:

CONFIDENTIAL