BIRTH CONTROL QUESTIONNAIRE (Previsit)

Instructions

Please answer the questions on this form and return the form to the nurse. If you don't already have an appointment, a nurse will review the form and contact you to schedule one.

If you think you need Plan B emergency contraceptive, please let the nurse know.

Name: _____ Birthdate: ____/____/____ Age: _____
Date: ____/____/____ Current Medications: _____
_____

PERIOD/MENSTRUAL HISTORY:
First day of my last period: ____/____/____
Have you had unprotected sex (without a condom or other form of birth control) since your last period? ____Yes ____No. If yes, approximate the date of unprotected sex: ____/____/____
My periods come about every ___ days. My periods usually last ___ days
My flow is: Scanty____ Moderate ____ Heavy ____ Painful ____
I began having menstrual periods at age_____.
I have/have had irregular periods: Yes____ No____
I have severe menstrual cramps: Yes____ No____
Do you have or have you ever had any of t he following (please check all that apply):
__Heart disease ___Blood clots ___High blood pressure ___Gallbladder problems
__Diabetes ___Chest pain ___Liver tumor or problems ___Breast cancer __Cervical Cancer
__Sexually Transmitted Infections(STI's) ___Stroke or paralysis ___Abnormal Pap Smear
__Infection in the tubes, ovaries, or uterus ___Female or abdominal surgery
__Severe headaches with blurred vision, nausea, or dizziness __Gestational trophoblastic disease
__Systemic Lupus erythematosus ___Organ transplant ___Distorted uterine cavity
Explain any answers checked:
_____
_____
Do you have any significant medical conditions or health problems: Yes____ No____
If yes, explain: _____
_____

Has a close relative ever had unexplained blood clots in the legs or lungs? Yes____ No____
If yes, please explain: _____
_____
Do you smoke cigarettes? Yes____ No____ If yes, how many per day? ____

BIRTH CONTROL (check all that apply):

I have never had sex____ I am sexually active____ I have a new sex partner____

Age of first intercourse___ Number of sex partners to date___ How long with present partner___

Pregnancies:

Have you ever been pregnant: Yes____ No____ Do you think you are pregnant: Yes____ No___

Have you been pregnant in the last month: Yes____ No____

Have you ever had a Pap test? Yes____ No____. If yes, approximate date____/____/____

Pap results (normal or abnormal): _____

Have you ever used any type of birth control before, including condoms? Yes____ No____

If yes, please explain: _____

_____

Have you ever taken Emergency Contraception such as Plan B? Yes____ No____

If yes, please list the date(s): _____

Do you have any concerns or questions? Yes____ No____

If yes, please explain: _____

_____

_____

_____

Name: _____ Date: ____/____/____

Signature: _____

_____ Email: _____

_____

This section for office use

Nurse/NP/MD Signature (reviewed by): _____ Date Reviewed: ____/____/____