The Contraceptive Choice Project
Baseline Clinical Form- Facilitator Scenario

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE
Paper	Heather	05/02/08
4. DOB 07/24/76	5. AGE 32 (YEARS)	6. TIME 08:20 (24hr)
7. REFERRED BY Relative	8. PRIMARY GYN HEALTH CARE PROVIDER Dr. Smith	
9. GRAVIDITY 7	10. PARITY 5	

GENERAL HEALTH INFORMATION

HEIGHT	WEIGHT (LBS)	BLOOD PRESSURE
5 feet 7 inches	186	109/070 mm Hg

SMOKER? ☐ Yes ☒ No

IF YES: For how many years? ______ Current # Cigarettes _____ per day/week (circle)

URINE PREGNANCY TEST

☒ Negative ☐ Positive (explain): ______

☐ Not done because Termination/Pregnancy Delivery/Miscarriage (circle) within prior 4 weeks

☐ Not done because participant is currently pregnant

NOTES:

CONTRACEPTION INFORMATION

Current contraception: nothing

Consistent use? ☐ Yes ☐ No

Date of last use: __ __/__ __/__ __

How long has participant been using this method? ______ years 4 months ______ days

Desired Method(s) (check all that apply):

☒ Hormonal IUD	☐ Copper IUD	☐ Implant	☐ Birth Control Pill
☐ Birth Control Shot	☐ Vaginal Ring	☐ Patch	☐ Diaphragm
☐ Condoms	☐ Nothing	☐ Other (specify): ______	

GYNECOLOGICAL HISTORY

Last Menstrual Period (LMP): 04/23/2008 (MM/DD/YYYY)

☐ Too long ago to remember ☐ Have never had a period

Periods are:	☒ Regular	☐ Irregular	
Periods come every:	27 to 30 days	☐ Too irregular to tell	
Periods are painful:	☐ Yes	☒ No	
Flow is:	☐ Light	☒ Moderate	☐ Heavy
Bleeding lasts:	3 to 4 days	☐ Too irregular to tell	
Last Intercourse: 04/20/2008 (MM/DD/YYYY)		☐ Used a Condom	
Year of Last Pap Smear: 2008 (YYYY)		☐ Unknown	☐ Never had pap
Result of last pap:	☒ Normal	☐ Abnormal	☐ Unknown

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IF PREGNANT

Gestational Week: _______ AND Estimated Due/End (circle) Date: __ __/__ __/__ __ __ __

OBSTETRICAL HISTORY

			MONTH/YEAR(S)
Number of pregnancies:	7		
# term births (≥ 37 weeks)	5	Date(s):	7/99, 5/02, 1/04, 2/06, 1/08 all NVD
# premature births (< 37 weeks)	0	Date(s):	
# miscarriages (< 20 weeks)	1	Date(s):	1/98
# stillbirths (≥ 20 weeks)	0	Date(s):	
# elective abortions	1	Date(s):	6/97
# ectopics	0	Date(s):	

INFECTION HISTORY

Have you ever had any of the following Infections?

INFECTION	Yes	No	Unknown	MONTH/YEAR(S)	TREATED? Yes	TREATED? No
Gonorrhea	☐	☒	☐		☐	☐
Chlamydia	☐	☒	☐		☐	☐
Trichomoniasis	☐	☒	☐		☐	☐
Syphilis	☐	☒	☐		☐	☐
Genital Herpes	☐	☒	☐		☐	☐
Genital Warts	☒	☐	☐	2006	☒	☐
HPV	☒	☐	☐	2004	☐	☒
BV	☒	☐	☐	2006	☒	☐

ALLERGIES

☒ No Known Allergies ☐ Yes (specify below)

ALLERGY	REACTION

CURRENT MEDICATIONS

	MEDICATION	DOSE (i.e. mg/pill)	HOW MANY TIMES A DAY
1.	N/A		
2.			
3.			
4.			

SURGICAL HISTORY

Record each relevant surgery or procedure on a separate line. (e.g. ovary removed, tubal or ectopic pregnancy, c/s, etc.)

SURGERY	YEAR PERFORMED
N/A	__ __ __ __
	__ __ __ __
	__ __ __ __

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MEDICAL HISTORY

Have you ever had any of the following?

CONDITION			YEAR(S) OF DIAGNOSIS	CURRENTLY BEING TREATED?			
Cancer Type:____	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
HIV	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Hypertension	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Heart Attack (MI)	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
CVA/TIA/Stroke	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Migraines	☐ N	☒ Y	2004	☒ N	☐ Y	☐ Resolved	☐ NA
IF YES: With Aura*?	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
High Cholesterol	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Thromboembolism (Blood clot)	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Diabetes	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Gestational Diabetes	☐ N	☒ Y	2008	☐ N	☐ Y	☒ Resolved	☐ NA
Thyroid Problems	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Liver Disease	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
PID	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Abnormal Vaginal Bleeding	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Uterine Fibroids	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Uterine Abnormalities	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Depression/Anxiety	☐ N	☒ Y	2007	☒ N	☐ Y	☐ Resolved	☐ NA
Other:____	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA
Other:____	☒ N	☐ Y	____	☐ N	☐ Y	☐ Resolved	☐ NA

*Ask participant: Do you see spots, have visual changes, have numbness in your hands or face, or have unusual sensations before your headaches?

ADDITIONAL COMMENTS: ☒ NA

____

____

____

IF VERBAL SIGNATURE OBTAINED

Date Verbal Signature Obtained: __ __/__ __/__ __

Time Verbal Signature Obtained: __ __:__ __ (24 hr)

Clinician Providing Verbal Consent: ____________ (Clinician Name)

Person Obtaining Verbal Consent: ____________

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SIGNATURES

FORM COMPLETED BY: Judy Pen

SIGNATURE: Judy Pen DATE: 05/02/08

REVIEWED BY: DR.__________ OR JWP WHNP

OR ☐ NA (give reason):__________

METHOD APPROVED: ☒ YES ☐ NO

IF NO PLEASE EXPLAIN: __________

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