

The Contraceptive Choice Project  
Baseline Clinical Form- Patient Scenario # 10

**PATIENT INFORMATION**

1. LAST NAME <u>Lamp</u>	2. FIRST NAME <u>Jamie</u>	3. TODAY'S DATE <u>02/12/11</u>
4. DOB <u>08/03/84</u>	5. AGE <u>26</u> (YEARS)	6. TIME <u>08:40</u> (24hr)
7. REFERRED BY <u>Friend</u>	8. PRIMARY GYN HEALTH CARE PROVIDER <u>Planned Parenthood</u>	
9. GRAVIDITY <u>2</u>	10. PARITY <u>0</u>	

**GENERAL HEALTH INFORMATION**

HEIGHT <u>5</u> feet <u>0</u> inches	WEIGHT (LBS) <u>123</u>	BLOOD PRESSURE <u>103/072</u> mm Hg
SMOKER? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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: condoms

Consistent use?  Yes  No

Date of last use: 02/10/11

How long has participant been using this method? 10 years \_\_\_\_\_ 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): 02/03/2011 (MM/DD/YYYY)

Too long ago to remember  Have never had a period

Periods are:  Regular  Irregular

Periods come every: 28 to 30 days  Too irregular to tell

Periods are painful:  Yes  No

Flow is:  Light  Moderate  Heavy

Bleeding lasts: 4 to 5 days  Too irregular to tell

Last Intercourse: 02/10/2011 (MM/DD/YYYY)  Used a Condom

Year of Last Pap Smear: 2010 (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**

Number of pregnancies: 2 MONTH/YEAR(S)  
 # term births (≥ 37 weeks) 0 Date(s): \_\_\_\_\_  
 # premature births (< 37 weeks) 0 Date(s): \_\_\_\_\_  
 # miscarriages (< 20 weeks) 0 Date(s): \_\_\_\_\_  
 # stillbirths (≥ 20 weeks) 0 Date(s): \_\_\_\_\_  
 # elective abortions 2 Date(s): 1/2004, 7/2008  
 # ectopics 0 Date(s): \_\_\_\_\_

**INFECTION HISTORY**

Have you ever had any of the following Infections?

INFECTION			MONTH/YEAR(S)	TREATED?
Gonorrhea	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<u>9/2010</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Chlamydia	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<u>9/2010</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Trichomoniasis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Syphilis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genital Herpes	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genital Warts	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
HPV	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
BV	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<u>7/2010</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**ALLERGIES**

No Known Allergies  Yes (specify below)

ALLERGY	REACTION
<u>latex</u>	<u>rash</u>
<u>sulfa drugs</u>	<u>rash</u>

**CURRENT MEDICATIONS**

MEDICATION	DOSE (i.e. mg/pill)	HOW MANY TIMES A DAY
1. <u>Primatene inhaler</u>	<u>2 puffs</u>	<u>As needed</u>
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
<u>N/A</u>	_____
_____	_____
_____	_____

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**MEDICAL HISTORY**

Have you ever had any of the following?

CONDITION			YEAR(S) OF DIAGNOSIS	CURRENTLY BEING TREATED?			
	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Resolved	<input type="checkbox"/> NA
Cancer Type: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack (MI)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA/TIA/Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES: With Aura*?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thromboembolism (Blood clot)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestational Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PID	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Vaginal Bleeding	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Fibroids	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Abnormalities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2006	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: heart murmur	<input type="checkbox"/>	<input checked="" type="checkbox"/>	1984	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*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

Pt took Emergency contraception/pills on three separate occasions during 1/2011.

**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: 02/12/11

REVIEWED BY: DR. \_\_\_\_\_ OR JWP WHNP  
OR  NA (give reason): \_\_\_\_\_

METHOD APPROVED:  YES  NO

IF NO PLEASE EXPLAIN: \_\_\_\_\_