

The Contraceptive Choice Project
Baseline Clinical Form- Patient Scenario # 2

PATIENT INFORMATION

1. LAST NAME <u>Chair</u>	2. FIRST NAME <u>Jane</u>	3. TODAY'S DATE <u>05/15/08</u>
4. DOB <u>06/19/86</u>	5. AGE <u>21</u> (YEARS)	6. TIME <u>11:18</u> (24hr)
7. REFERRED BY <u>Friend</u>	8. PRIMARY GYN HEALTH CARE PROVIDER <u>A community clinic</u>	
9. GRAVIDITY <u>5</u>	10. PARITY <u>1</u>	

GENERAL HEALTH INFORMATION

HEIGHT <u>5</u> feet <u>09</u> inches	WEIGHT (LBS) <u>157</u>	BLOOD PRESSURE <u>123/078</u> mm Hg
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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? 1 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): 02/01/2008 (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: 05/01/2008 (MM/DD/YYYY) Used a Condom

Year of Last Pap Smear: 2007 (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:

5

term births (≥ 37 weeks)

1

Date(s):

MONTH/YEAR(S)
05/2006 NVD

premature births (< 37 weeks)

0

Date(s):

miscarriages (< 20 weeks)

1

Date(s):

12/2007

stillbirths (≥ 20 weeks)

0

Date(s):

elective abortions

3

Date(s):

07/2003, 1/2005, 3/31/2008

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>2006</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>2006</u>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Trichomoniasis	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<u>2006</u>	<input checked="" 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 type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown		<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALLERGIES

No Known Allergies Yes (specify below)

ALLERGY	REACTION
<u>Penicillin</u>	<u>throat closes up</u>

CURRENT MEDICATIONS

MEDICATION	DOSE (i.e. mg/pill)	HOW MANY TIMES A DAY
<u>N/A</u>		

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 type="checkbox"/>	<input checked="" type="checkbox"/>	2006	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES: With Aura*?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2006	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	_____	<input 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"/>
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

Medication for migraine headaches is too expensive.
Pt self treats with excedrin migraine.

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: 05/15/08

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

METHOD APPROVED: YES NO

IF NO PLEASE EXPLAIN: _____