

The Contraceptive Choice Project
Baseline Clinical Form- Patient Scenario # 6

PATIENT INFORMATION

1. LAST NAME <u>Glass</u>	2. FIRST NAME <u>Sarah</u>	3. TODAY'S DATE <u>06/10/11</u>
4. DOB <u>03/31/86</u>	5. AGE <u>25</u> (YEARS)	6. TIME <u>11:15</u> (24hr)
7. REFERRED BY <u>friend</u>	8. PRIMARY GYN HEALTH CARE PROVIDER <u>Dr. Smith</u>	
9. GRAVIDITY <u>6</u>	10. PARITY <u>3</u>	

GENERAL HEALTH INFORMATION

HEIGHT <u>5</u> feet <u>4</u> inches	WEIGHT (LBS) <u>235</u>	BLOOD PRESSURE <u>130/084</u> mm Hg
SMOKER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
IF YES: For how many years? <u>5</u> Current # Cigarettes <u>10</u> 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: 05/11/11

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): 05/24/2011 (MM/DD/YYYY)

Too long ago to remember Have never had a period

Periods are: Regular Irregular

Periods come every: 28 to 28 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: 05/11/2011 (MM/DD/YYYY) Used a Condom

Year of Last Pap Smear: 2011 (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: 6
 # term births (≥ 37 weeks) 2 Date(s): 05/2005, 05/2008 - Both NVD
 # premature births (< 37 weeks) 1 Date(s): 5/2010
 # miscarriages (< 20 weeks) 1 Date(s): 06/2009
 # stillbirths (≥ 20 weeks) 0 Date(s): _____
 # elective abortions 2 Date(s): 04/2004, 01/2007
 # ectopics 0 Date(s): _____

INFECTION HISTORY

Have you ever had any of the following Infections?

INFECTION				MONTH/YEAR(S)	TREATED?	
Gonorrhea	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chlamydia	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	_____	<input 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 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>Latex</u>	<u>rash</u>
<u>Penicillin</u>	<u>hives</u>

CURRENT MEDICATIONS

MEDICATION	DOSE (i.e. mg/pill)	HOW MANY TIMES A DAY
1. <u>iron pills</u>	<u>unknown</u>	<u>1 x day</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>C/S</u>	<u>2010</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 type="checkbox"/>	<input checked="" type="checkbox"/>	2004	<input checked="" 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 type="checkbox"/>	<input checked="" type="checkbox"/>	2008	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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

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: 06/10/11

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

METHOD APPROVED: YES NO

IF NO PLEASE EXPLAIN: _____