The Contraceptive Choice Project
Baseline Clinical Form- Patient Scenario # 7

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE
Bowl	April	02/18/10
4. DOB	5. AGE	6. TIME
06/08/79	30 (YEARS)	18:09 (24hr)
7. REFERRED BY	8. PRIMARY GYN HEALTH CARE PROVIDER	
Friend	Dr. Smith	
9. GRAVIDITY	10. PARITY	
4	2	

GENERAL HEALTH INFORMATION

HEIGHT	WEIGHT (LBS)	BLOOD PRESSURE
5 feet 2 inches	131	116/72 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: Condoms

Consistent use? ☒ Yes ☐ No

Date of last use: 02/14/10

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): 02/08/2010 (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: 5 to 7 days ☐ Too irregular to tell

Last Intercourse: 02/14/2010 (MM/DD/YYYY) ☒ Used a Condom

Year of Last Pap Smear: 2009 (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:	4		
# term births (≥ 37 weeks)	2	Date(s):	09/2005, 11/2008 Both NVD
# premature births (< 37 weeks)	0	Date(s):	
# miscarriages (< 20 weeks)	1	Date(s):	08/2007
# stillbirths (≥ 20 weeks)	0	Date(s):	
# elective abortions	0	Date(s):	
# ectopics	1	Date(s):	04/2007

INFECTION HISTORY

Have you ever had any of the following Infections?

INFECTION				MONTH/YEAR(S)	TREATED?	
Gonorrhea	☒ Yes	☐ No	☐ Unknown	10/2006	☒ Yes	☐ No
Chlamydia	☒ Yes	☐ No	☐ Unknown	10/2006	☒ Yes	☐ No
Trichomoniasis	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
Syphilis	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
Genital Herpes	☒ Yes	☐ No	☐ Unknown	10/2000	☐ Yes	☒ No
Genital Warts	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
HPV	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
BV	☒ Yes	☐ No	☐ Unknown	2001	☒ Yes	☐ No

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
tubal pregnancy	2007

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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	_____	☐ 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	_____	☐ N	☐ Y	☐ Resolved	☐ NA
Thyroid Problems	☒ N	☐ Y	_____	☐ N	☐ Y	☐ Resolved	☐ NA
Liver Disease	☒ N	☐ Y	_____	☐ N	☐ Y	☐ Resolved	☐ NA
PID	☐ N	☒ Y	2006	☐ 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	_____	☐ 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: _____

SIGNATURES

FORM COMPLETED BY: Judy Pen

SIGNATURE: Judy Pen DATE: 02/18/10

REVIEWED BY: DR._____ OR JWP WHNP

OR ☐ NA (give reason):_____

METHOD APPROVED: ☒ YES ☐ NO

IF NO PLEASE EXPLAIN: _____