The Contraceptive Choice Project
Baseline Clinical Form- Patient Scenario # 8

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE
Plate	Rachel	03/09/11
4. DOB 04/28/86	5. AGE 24 (YEARS)	6. TIME 09:13 (24hr)
7. REFERRED BY friend	8. PRIMARY GYN HEALTH CARE PROVIDER none	
9. GRAVIDITY 3	10. PARITY 1	

GENERAL HEALTH INFORMATION

HEIGHT	WEIGHT (LBS)	BLOOD PRESSURE
5 feet 5 inches	234	140/090 mm Hg

SMOKER? ☐ Yes ☒ No

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

URINE PREGNANCY TEST

☐ Negative ☒ Positive (explain): surgical abortion on 2/26/11

☐ 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: 02/22/11

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): 12/21/2010 (MM/DD/YYYY)

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

Periods are: ☒ Regular ☐ Irregular

Periods come every: 26 to 26 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: 03/07/2011 (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

			MONTH/YEAR(S)
Number of pregnancies:	3		
# term births (≥ 37 weeks)	1	Date(s):	10/2005 NVD
# premature births (< 37 weeks)	0	Date(s):	
# miscarriages (< 20 weeks)	0	Date(s):	
# stillbirths (≥ 20 weeks)	0	Date(s):	
# elective abortions	2	Date(s):	2/2010, 2/26/2011
# ectopics	0	Date(s):	

INFECTION HISTORY

Have you ever had any of the following Infections?

	INFECTION			MONTH/YEAR(S)	TREATED?	
Gonorrhea	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
Chlamydia	☒ Yes	☐ No	☐ Unknown	08/2010	☒ Yes	☐ No
Trichomoniasis	☒ Yes	☐ No	☐ Unknown	08/2010	☒ Yes	☐ No
Syphilis	☒ Yes	☐ No	☐ Unknown	08/2010	☒ Yes	☐ No
Genital Herpes	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
Genital Warts	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
HPV	☐ Yes	☒ No	☐ Unknown		☐ Yes	☐ No
BV	☒ Yes	☐ No	☐ Unknown	08/2010	☒ Yes	☐ No

ALLERGIES

☐ No Known Allergies ☒ Yes (specify below)

ALLERGY	REACTION
shellfish	rash

CURRENT MEDICATIONS

	MEDICATION	DOSE (i.e. mg/pill)	HOW MANY TIMES A DAY
1.	Albuterol	2 puffs	as needed
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	2005	☒ 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	2005	☒ N	☐ Y	☐ Resolved	☐ NA
Thromboembolism (Blood clot)	☒ N	☐ Y	______	☐ N	☐ Y	☐ Resolved	☐ NA
Diabetes	☒ N	☐ Y	______	☐ N	☐ Y	☐ Resolved	☐ NA
Gestational Diabetes	☒ N	☐ Y	2005	☐ 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	2010	☒ 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: 03/09/11

REVIEWED BY: DR.__________ OR JWP WHNP

OR ☐ NA (give reason):__________

METHOD APPROVED: ☒ YES ☐ NO

IF NO PLEASE EXPLAIN: __________

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