The Contraceptive Choice Project
Baseline Clinical Form- Patient Scenario # 9

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE
Sofa	Valerie	03/24/11
4. DOB 11/05/82	5. AGE 28 (YEARS)	6. TIME 15:10 (24hr)
7. REFERRED BY Family member	8. PRIMARY GYN HEALTH CARE PROVIDER Dr. Smith	
9. GRAVIDITY 4	10. PARITY 1	

GENERAL HEALTH INFORMATION

HEIGHT	WEIGHT (LBS)	BLOOD PRESSURE
5 feet 3 inches	120	113/079 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: Pills

Consistent use? ☒ Yes ☐ No

Date of last use: 03/23/11

How long has participant been using this method? 2 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): 02/25/2011 (MM/DD/YYYY)

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

Periods are:	☒ Regular	☐ Irregular	
Periods come every:	23 to 23 days	☐ Too irregular to tell	
Periods are painful:	☐ Yes	☒ No	
Flow is:	☐ Light	☒ Moderate	☐ Heavy
Bleeding lasts:	5 to 5 days	☐ Too irregular to tell	
Last Intercourse: 03/21/2011 (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:	4		
# term births (≥ 37 weeks)	0	Date(s):	
# premature births (< 37 weeks)	1	Date(s):	06/2009 - C/S
# miscarriages (< 20 weeks)	2	Date(s):	11/2007, 5/2008
# stillbirths (≥ 20 weeks)	0	Date(s):	
# elective abortions	1	Date(s):	1/2008
# ectopics	0	Date(s):	

INFECTION HISTORY

Have you ever had any of the following Infections?

INFECTION	Yes	No	Unknown	MONTH/YEAR(S)	TREATED? Yes	TREATED? No
Gonorrhea	☒	☐	☐	2006	☒	☐
Chlamydia	☒	☐	☐	2006	☒	☐
Trichomoniasis	☒	☐	☐	2006	☒	☐
Syphilis	☐	☒	☐		☐	☐
Genital Herpes	☐	☒	☐		☐	☐
Genital Warts	☒	☐	☐	2009	☒	☐
HPV	☐	☒	☐		☐	☐
BV	☐	☒	☐		☐	☐

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
c/s	2009
colposcopy	2009

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MEDICAL HISTORY

Have you ever had any of the following?

CONDITION	N	Y	YEAR(S) OF DIAGNOSIS	CURRENTLY BEING TREATED? N	Y	Resolved	NA
Cancer Type:______	☒	☐		☐	☐	☐	☐
HIV	☒	☐		☐	☐	☐	☐
Hypertension	☐	☒	2009	☐	☐	☒	☐
Heart Attack (MI)	☒	☐		☐	☐	☐	☐
CVA/TIA/Stroke	☒	☐		☐	☐	☐	☐
Migraines	☐	☒	2008	☒	☐	☐	☐
IF YES: With Aura*?	☒	☐		☐	☐	☐	☐
High Cholesterol	☒	☐		☐	☐	☐	☐
Thromboembolism (Blood clot)	☒	☐		☐	☐	☐	☐
Diabetes	☒	☐		☐	☐	☐	☐
Gestational Diabetes	☒	☐		☐	☐	☐	☐
Thyroid Problems	☒	☐		☐	☐	☐	☐
Liver Disease	☒	☐		☐	☐	☐	☐
PID	☒	☐		☐	☐	☐	☐
Abnormal Vaginal Bleeding	☒	☐		☐	☐	☐	☐
Uterine Fibroids	☒	☐		☐	☐	☐	☐
Uterine Abnormalities	☒	☐		☐	☐	☐	☐
Depression/Anxiety	☒	☐		☐	☐	☐	☐
Other:______	☒	☐		☐	☐	☐	☐
Other:______	☒	☐		☐	☐	☐	☐

*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: 03/24/11

REVIEWED BY: DR.________ OR JWP WHNP

OR ☐ NA (give reason):________

METHOD APPROVED: ☒ YES ☐ NO

IF NO PLEASE EXPLAIN:________