

**PATIENT INFORMATION**

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE ___/___/___
4. DOB ___/___/___	5. AGE (YEARS)	6. TIME __:__(24hr)
7. GRAVIDITY	8. PARITY	

**ALLERGIES**

No Known Allergies     Yes (specify below)

<u>ALLERGY</u>	<u>REACTION</u>
_____	_____
_____	_____
_____	_____

**BIRTH CONTROL**

CONTRACEPTIVE METHOD	DISPENSED	RX	SCHEDULED
<input type="checkbox"/> Mirena OR <input type="checkbox"/> ParaGard, placed as directed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ibuprofen 200 mg po x ___ for pain			
<input type="checkbox"/> Misoprostol 200 mcg intravaginally			
<input type="checkbox"/> Misoprostol 200 mcg buccally			
<input type="checkbox"/> Implanon, subdermal, to be placed as directed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pills: _____ as directed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> DepoProvera 150 mg IM x 1 now, repeat Q 3 Months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> NuvaRing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ortho Evra Patch as directed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STI TREATMENT**

TREATMENT	DISPENSED	RX
<input type="checkbox"/> Azithromycin 1 gm po x 1 for chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Doxycycline 100 mg po bid x 7 days for chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ceftriaxone 250 mg IM x 1 for gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Suprax 400 mg po x 1 for gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Benzathine penicillin G 2.4 million units IM x 1 for syphilis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Metronidazole 2 gm po x 1 for trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other*: _____	<input type="checkbox"/>	<input type="checkbox"/>

\*Record medication, dose, route, and frequency.

**OTHER PRESCRIPTIONS DISPENSED**

PRESCRIPTION	DISPENSED	RX
<input type="checkbox"/> Metronidazole 500 mg po bid x 7 days for bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Naprosyn 500 mg 1 bid prn	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anaprox DS 1 bid prn	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diflucan 150mg po x 1	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other*: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other*: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other*: _____	<input type="checkbox"/>	<input type="checkbox"/>

\*Record medication, dose, route, and frequency.

**IF VERBAL SIGNATURE OBTAINED**

Date Verbal Signature Obtained: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Time Verbal Signature Obtained: \_\_ \_\_ : \_\_ \_\_ (24 hr)

Clinician Providing Verbal Consent: \_\_\_\_\_ (Clinician Name)

Person Obtaining Verbal Consent: \_\_\_\_\_

**CLINICIAN SIGNATURE**

Clinician's Signature: \_\_\_\_\_

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_