[Insert Clinic Name Here]
Baseline Clinical Form

PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TODAY'S DATE __ __/__ __/__ __
4. DOB __ __/__ __/__ __	5. AGE __ __ (YEARS)	6. TIME __ __:__ __ (24hr)
7. REFERRED BY	8. PRIMARY GYN HEALTH CARE PROVIDER	
9. GRAVIDITY	10. PARITY	

GENERAL HEALTH INFORMATION

HEIGHT _____ feet _____ inches	WEIGHT (LBS)	BLOOD PRESSURE __ __ __/__ __ __ 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: ____

Consistent use? ☐ Yes ☐ No

Date of last use: __ __/__ __/__ __

How long has participant been using this method? _______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): __ __/__ __/__ __ __ __ (MM/DD/YYYY)

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

Periods are: ☐ Regular ☐ Irregular

Periods come every: ____to _____days ☐ Too irregular to tell

Periods are painful: ☐ Yes ☐ No

Flow is: ☐ Light ☐ Moderate ☐ Heavy

Bleeding lasts: ____ to ____days ☐ Too irregular to tell

Last Intercourse: __ __/__ __/__ __ __ __ (MM/DD/YYYY) ☐ Used a Condom

Year of Last Pap Smear: __ __ __ __ (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:	________		
# term births (≥ 37 weeks)	________	Date(s):	________________________
# premature births (< 37 weeks)	________	Date(s):	________________________
# miscarriages (< 20 weeks)	________	Date(s):	________________________
# stillbirths (≥ 20 weeks)	________	Date(s):	________________________
# elective abortions	________	Date(s):	________________________
# ectopics	________	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	____________	☐ Yes	☐ No
Trichomoniasis	☐ Yes	☐ No	☐ Unknown	____________	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No	☐ Unknown	____________	☐ 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	____________	☐ 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.________________	________________	________________
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
________________________________	__ __ __ __
________________________________	__ __ __ __
________________________________	

[Insert Clinic Name Here]
Baseline Clinical Form

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	________	☐ 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 patient: 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: ____

SIGNATURE: ____DATE: __ __/__ __/__ ___

REVIEWED BY: DR.____________________________ OR ______________________WHNP

OR ☐ NA (give reason):____

METHOD APPROVED: ☐ YES ☐ NO

IF NO PLEASE EXPLAIN: ____