Interim Clinical Form

Date: __ __/__ __/20__ __ Time: __ __:__ __
M M D D Y Y (24 Hour clock)

Name of patient:______________,_____________ DOB:__ __/__ __/__ __
(Last) (First)

Reason for visit:

- ☐ IUD insertion
- ☐ IUD check
- ☐ IUD removal
- ☐ Implant insertion
- ☐ Implant check
- ☐ Implant removal
- ☐ STD check
- ☐ Urine pregnancy test
- ☐ Method change from ____________ to ____________
- ☐ Method replenishment
- ☐ Other: _________________________

Chief complaint:

____

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Weight: _________ lbs/kgs (circle one) ☐ N/A

Vital Signs: Blood Pressure ☐☐☐ / ☐☐☐ mm Hg ☐ N/A

Urine pregnancy test: ☐ Neg ☐ Pos ☐ Not done. Reason:__________________

Any change in medications from initial visit: (medication/amount/frequency)

1. _____________/ _____________/_______________
2 _____________/ _____________/_______________
3. _____________/ _____________/_______________

Smoker? ☐ Yes ☐ No

PPD ________ or # cigs ______per day/week (circle one)

LMP of __ __/__ __/20__ __ or ☐ UNK (give reason):___________________________
M M D D Y Y

Was it normal? ☐ Yes ☐ No

Clinician progress note: ☐ N/A or

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Reviewed by: Dr. ______________________ or __________________WHNP

Signature:______________________________________ Date:___________

or ☐ N/A (give reason) ____

Form completed by: ____

Signature:_____________________________________Date: ___________