Women's Contraceptive Visit Questionnaire (Pt. to Complete)

Date: _____

NAME: Marital Status S M W D SEP DATE OF BIRTH:

SCHOOL/ UNIVERSITY OCCUPATION/ EMPLOYER REFERRED BY:

REASON FOR VISIT

PAST MEDICAL & FAMILY HISTORY -- PLEASE CHECK IF YOU (PERS) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS

	PERS	FAM			PERS	FAM
1. WT. LOSS/GAIN	☐			13. URINARY INFECTIONS	☐	☐
2. HEADACHES / MIGRAINE	☐			14. BLOOD TRANSFUSIONS	☐	☐
3. HEART DISEASE ☐ VALVULAR DIS ☐	☐	☐		15. ANEMIA/BLOOD DISORDER	☐	☐
RHEUMATIC DIS ☐				16. ACNE/COMPLEXION DISORDER	☐	☐
4. HIGH BLOOD PRESSURE	☐	☐		SKIN DISEASE (OTHER)	☐	☐
5. HIGH CHOLESTEROL	☐	☐		17. DIABETES	☐	☐
6. RESPIRATORY (LUNG) DISEASE	☐	☐		18. THYROID DISEASE	☐	☐
7. BREAST DISEASE	☐	☐		19. CANCER (TYPE)	☐	☐
8. JAUNDICE / HEPATITIS	☐	☐		20. EPILEPSY / SEIZURES	☐	☐
9. HIATAL HERNIA (REFLUX)	☐	☐		21. ARTHRITIS -- JOINT PAIN	☐	☐
10. PEPTIC ULCER (STOMACH)	☐	☐		22. ANXIETY / DEPRESSION	☐	☐
11. BOWEL DISEASE	☐	☐		23. SLEEP PROBLEMS	☐	☐
12. KIDNEY DISEASE	☐	☐				

HOSPITAL ADMISSIONS -- *LIST THOSE OPERATIONS & SERIOUS ILLNESSES WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)*

YEAR REASON FOR ADMISSION / HOSPITAL YEAR REASON FOR ADMISSION / HOSPITAL

MEDICATIONS -- *LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (DOSAGE-FREQUENCY) -- INCLUDE OVER THE COUNTER DRUGS*

OBSTETRICAL HISTORY Number of PREGNANCIES ☐ PREMATURE ☐ MISCARRIAGES ☐ ABORTIONS ☐ LIVING BABIES CHILDREN

MENSTRUAL HISTORY AGE AT FIRST PERIOD? _____ IF MENSTRUATING -- DATE OF LAST PERIOD (1ST DAY)?_____

PERIODS ARE: ☐ REGULAR ☐ SOMEWHAT IRREGULAR ☐ COMPLETELY IRRREGULAR PERIOD INTERVAL (1ST day TO 1ST day) number of days?____ DURATION OF BLEEDING FROM _____TO_____DAYS

BLEEDING (SPOTTING) IN BETWEEN PERIODS? YES☐ NO☐ WITH YOUR PERIODS -- DO YOU HAVE? ☐ PAIN ☐ CRAMPS ☐ BLOATING

TIME LOST FROM SCHOOL/WORK BECAUSE OF PERIODS ☐ YES ☐ NO

BIRTH CONTROL CURRENT METHOD? HOW LONG? IF PILL -- BRAND? PAST METHODS?

COMMENTS/PROBLEMS:_____

SEXUAL HISTORY ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO IS INTERCOURSE SATISFACTORY? ☐ YES ☐ NO

WISH TO DISCUSS? ☐ YES ☐ NO PAIN / BLEEDING WITH INTERCOURSE? ☐ YES ☐ NO

PELVIC EXAM DATE OF LAST EXAM **PAP TEST** DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

INFECTIONS AT PRESENT -- ANY ABNORMAL VAGINAL DISCHARGE ☐YES ☐NO *History of:* ☐ YEAST INFECTIONS ☐ CHLAMYDIA ☐ GONORRHEA ☐ TRICHOMONAS ☐ HERPES ☐ BACTERIAL INFECTION ☐ BLADDER / URINARY INFECTIONS

BREASTS DO YOU -- ROUTINELY CHECK YOUR BREASTS ☐ YES ☐ NO HAVE - ☐ PAINFUL ☐ TENDER ☐ LUMPY BREASTS?

HAVE ANY NIPPLE DISCHARGE? ☐ YES ☐ NO HAVE ANY OTHER CONCERNS? ☐ YES ☐ NO

SOCIAL HISTORY SMOKING -- CIG/DAY ☐ # YEARS ☐ ALCOHOL -- OZ/WK ☐ COFFEE CUPS/DAY ☐ STREET DRUGS