

Whole Woman's Health of Austin
Transforming Healthcare One Woman at a Time
 8401 North IH 35 Suite 200 * Austin TX 78753
 (512) 250 – 1005 * (800) 282 – 1005

Contraceptive History & Screening

Name: _____ Date: _____

	Method(s) you are using now	Method(s) you would like to use	Method(s) you used in the past	Method(s) that have caused you trouble
Oral Contraceptive Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ortho Evra Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuva Ring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depo-Provera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle whether or not you have ever had any of the following:

Clots in legs, lungs or elsewhere	NO	YES
A stroke, heart attack or chest pain	NO	YES
Known or suspected cancer of the breast or sex organs.....	NO	YES
Severe liver disease, mononucleosis or hepatitis.....	NO	YES
Breast nodules, fibrocystic disease of the breast or abnormal mammogram	NO	YES
Gallbladder disease	NO	YES
Diabetes.....	NO	YES
Fibroid tumors of the uterus.....	NO	YES
Asthma	NO	YES
Thyroid abnormalities	NO	YES
Depression or mood swings	NO	YES
High blood pressure	NO	YES
Migraine headaches.....	NO	YES
Heart or Kidney disease	NO	YES
Epilepsy/Seizures	NO	YES
Sickle cell disease or trait.....	NO	YES
Do you now have any unusual bleeding that has not been diagnosed?.....	NO	YES
Are you currently breast feeding?	NO	YES

Do you smoke? NO YES Packs per day _____ # of years _____

Do you take any medications on a regular basis? _____

Is there anything else we need to know at this time? _____

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CONSENT FOR CONTRACEPTION

Hormonal Methods

I request that Whole Woman's Health administer the following method to me (initial):

- | | |
|---|--|
| <input type="checkbox"/> Combined oral contraceptives/
birth control pills | <i>Info sheet given (staff initials):</i>
_____ |
| <input type="checkbox"/> Progestin only oral contraceptives/
birth control pills | _____ |
| <input type="checkbox"/> Ortho Evra patch | _____ |
| <input type="checkbox"/> Nuva Ring | _____ |
| <input type="checkbox"/> Depo provera/DMPA injection | _____ |
| <input type="checkbox"/> Mirena IUD | _____ |
| <input type="checkbox"/> Paraguard IUD | _____ |

Non-hormonal methods

- Info sheet given (staff initials):*
- | |
|---|
| <input type="checkbox"/> Diaphragm |
| <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Condoms and spermicides/foam |

I have received written information on the method I've chosen: how it works, how to use it, side effects, contraindications, and effectiveness. I have had the opportunity to ask questions and discuss the method.

Signature: _____ Date: _____

Staff Witness: _____ Date: _____