

Whole Woman's Health of Baltimore

7648 Bel Air Road * Baltimore MD 21236

(410) 661-2900 * (800)997-7942

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):

Info sheet given (staff initials):

- Combined oral contraceptives/
birth control pills
- Progestin only oral contraceptives/
birth control pills
- Ortho Evra patch
- Nuva Ring
- Depo provera/DMPA injection
- Mirena IUD
- Paraguard IUD

Non-hormonal methods

Info sheet given (staff initials):

- Diaphragm
- Tubal Ligation
- Vasectomy
- 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: _____