

Planned Parenthood of Southeastern Virginia
 403 Yale Dr., Hampton, Virginia 23666 (757) 826-2079
 425 West 20th Street, Suite 6, Norfolk, Virginia 23517 (757) 624-9224
 5441 Virginia Beach Blvd., Suite 102, Va Beach, Virginia 23462 (757) 473-8116

Hormonal Contraception without Physical Exam

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Patient Label

Name: _____ Date _____ DOB: _____ Age: _____

When did your last menstrual period start? _____ Was it normal for you? Yes No

When not on birth control, have you ever gone months without getting a period? Yes No

Date of last pregnancy: _____ N/A

Yes No Do you have any abnormal bleeding or vaginal discharge?

Yes No Have you had unprotected sexual intercourse since your last period?

Yes No Do you think you might be pregnant?

Yes No Are you breastfeeding now?

Yes No Do you use tobacco? Smoking Chewing If yes, how much a day?

Yes No Are you allergic to any drugs or medications or latex?

Yes No Are you taking any medications (including vitamins), herbs or drugs?
If yes, which ones?

Yes No Are you planning major surgery that will require long-term bed rest?

Have you had any of the following?

Yes No stroke

Yes No blood clots

Yes No heart attack or other heart disease

Yes No serious heart valve problems

Yes No breast cancer or lumps in your breast

Yes No other cancer

Yes No diabetes

Yes No seizures

Yes No high blood pressure

Yes No high cholesterol

Yes No gall bladder disease (not including having your gall bladder removed)

Yes No severe long-term depression

Yes No migraine headaches: If yes, do you ever have vision changes that
 start before the headache last up to one hour
 resolve before the headache begins / See Headache questionnaire

Yes No liver problems

Yes No bone problems – fragility fractures or osteoporosis

Yes No eating disorder

Yes No problems with vaginal muscles or severe constipation

Yes No serious illness –If yes, what?

Name: _____ Date _____ DOB: _____ Age: _____		
Family History		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a father or brother had a heart attack or stroke before age 55?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a mother or sister had a heart attack or stroke before age 65?	
Past experience with hormonal birth control		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you used hormonal birth control before? If yes, circle which one: Pills Patch Ring DMPA Lunelle Norplant/Implanon If birth control pills, which pill(s) _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with them? If yes, describe _____	
General Health Questions		When?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last routine exams (breast and pelvic) were normal? <input type="checkbox"/> N/A	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a Pap test?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an abnormal Pap test? If yes, result was: _____ Treatment was: <input type="checkbox"/> Cryotherapy <input type="checkbox"/> LEEP <input type="checkbox"/> Follow-up Paps <input type="checkbox"/> None <input type="checkbox"/> Other Follow up Paps were: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> None	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last mammogram was normal? <input type="checkbox"/> N/A If 40 years or older: breast exam (see next page) Offered: clinical breast exam (CBE)/ Mammogram Clinical breast exam: accepts / declines **If client declines both CBE & mammogram: have client sign: I realize that I am 40 years old or older with an increased risk of breast cancer since breast cancer is often only diagnosed through clinical breast exam and mammogram. I realize that I am putting myself at increased risk of Breast Cancer by refusing the clinical breast exam and mammogram. Additionally I understand that any hormones will makes a Breast Cancer grow if undiagnosed. I accept these risks. Client Signature _____/witness _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently sexually active? If yes , circle all that apply: New relationship Long-term relationship Multiple partners Do you use condoms? <input type="checkbox"/> always <input type="checkbox"/> sometimes <input type="checkbox"/> never	

Client Signature: _____ Date: _____

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