

CONTRACEPTIVE HISTORY FORM (HOPE)

Date _____		Affix patient label here
Age _____		
When did your last period start? _____ Was it normal for you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
When not on birth control, have you ever gone months without getting a period? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of last pregnancy _____ <input type="checkbox"/> N/A		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any abnormal bleeding or vaginal discharge?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had unprotected sex since your last period?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you think you might be pregnant?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you breastfeeding now?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Smoking <input type="checkbox"/> Chewing. If yes, how much a day?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to any drugs, medications, or latex?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking any medications (including vitamins), herbs, or drugs? If yes, which ones?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you planning major surgery that will require long-term bed rest?	
Have you had any of the following?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	stroke	
<input type="checkbox"/> Yes <input type="checkbox"/> No	blood clot or blood clotting disorder — If yes, are you taking medicine now?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	heart attack or other heart disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No	serious heart-valve problems	
<input type="checkbox"/> Yes <input type="checkbox"/> No	breast cancer or lumps in your breast	
<input type="checkbox"/> Yes <input type="checkbox"/> No	other cancer — If yes, what kind?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	diabetes	
<input type="checkbox"/> Yes <input type="checkbox"/> No	seizures	
<input type="checkbox"/> Yes <input type="checkbox"/> No	high blood pressure	
<input type="checkbox"/> Yes <input type="checkbox"/> No	high cholesterol	
<input type="checkbox"/> Yes <input type="checkbox"/> No	gall bladder disease (not including having your gall bladder removed)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	severe long-term depression	
<input type="checkbox"/> Yes <input type="checkbox"/> No	migraine headaches — If yes, do you ever have vision changes that <input type="checkbox"/> start before the headache <input type="checkbox"/> last up to one hour <input type="checkbox"/> go away before the headache begins	
<input type="checkbox"/> Yes <input type="checkbox"/> No	liver problems	



Planned Parenthood
of Nassau County, Inc.

540 Fulton Ave. Hempstead, NY 11550
110 School Street, Glen Cove, NY 11542
35 Carmans Road, Massapequa, NY 11758
(516) 750-2500

Sample Brief Contraceptive Hx Form

III-A-4

Revised June 2009

<input type="checkbox"/> Yes <input type="checkbox"/> No	lupus (Systemic Lupus Erythematosus)
<input type="checkbox"/> Yes <input type="checkbox"/> No	bone problems — fragility fractures or osteoporosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	eating disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	problems with vaginal muscles or severe constipation
<input type="checkbox"/> Yes <input type="checkbox"/> No	bariatric (weight loss) surgery? If yes, what kind?
<input type="checkbox"/> Yes <input type="checkbox"/> No	other serious illness — If yes, what?
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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a family member(s) had a serious blood clot (DVT) or blood clotting disorder?
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/POPS Patch Ring DMPA 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last routine breast and pelvic exams were normal? <input type="checkbox"/> N/A If not normal, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last mammogram was 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	Are you having intercourse? If yes , circle all that apply: Oral sex Vaginal sex Anal sex 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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Name: _____ Patient #: _____	
Notes	
O: <input type="checkbox"/> B/P _____ <input type="checkbox"/> HT _____ <input type="checkbox"/> WT _____ (as indicated)	
Pregnancy test (as indicated) <input type="checkbox"/> Pos <input type="checkbox"/> Neg Type _____ Other _____	
Client Information for Informed Consent/Client Instruction	
<input type="checkbox"/> COC CIIC/CI <input type="checkbox"/> Ring CIIC/CI <input type="checkbox"/> Patch CIIC/CI <input type="checkbox"/> DMPA CIIC/CI	<input type="checkbox"/> FDA insert
<input type="checkbox"/> POP CIIC/CI <input type="checkbox"/> Implanon CIIC/CI <input type="checkbox"/> Special Conditions CIIC <input type="checkbox"/> EC CIIC/CI	
<input type="checkbox"/> all-methods brochure	<input type="checkbox"/> encouraged parental involvement
<input type="checkbox"/> STI/condom information	<input type="checkbox"/> encouraged smoking cessation
<input type="checkbox"/> folic acid/multivitamin	<input type="checkbox"/> encouraged Pap or Pap follow-up
	<input type="checkbox"/> encouraged well-woman visit
	<input type="checkbox"/> encouraged STI screening
	<input type="checkbox"/> encouraged mammogram

Staff Signature _____
Date

A:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any contraindications to progestin-only contraception?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any contraindications to combined hormonal contraception?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any special conditions? If yes, what? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Needs referral for further medical evaluation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Appropriate candidate to begin hormonal contraception
<input type="checkbox"/> Yes <input type="checkbox"/> No	Appropriate candidate for immediate use of ECP
	Other _____
P:	
<input type="checkbox"/> History/Chart Reviewed	Lab work <input type="checkbox"/> none indicated <input type="checkbox"/> mammogram
	<input type="checkbox"/> other _____
Further medical evaluation:	<input type="checkbox"/> none indicated <input type="checkbox"/> referred for physical exam
	<input type="checkbox"/> referred for Pap <input type="checkbox"/> other _____
NOTES: _____	

Staff signature /date: _____	



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Rxs	<input type="checkbox"/> Pill _____ sig (1) PO QD Refill x _____
	<input type="checkbox"/> DMPA 150 mg IM Q 12-13 w; Refill x _____ <input type="checkbox"/> Injection given: DMPA 150 mg _____ Lot# _____ Staff Initials _____
	<input type="checkbox"/> DMPA 104 mg SQ Q 12-13 w; Refill x _____ <input type="checkbox"/> Injection given: DMPA 104 mg SQ _____ Lot# _____ Staff Initials _____
	<input type="checkbox"/> Ortho Evra Patch #3: sig: 1 patch dermally Q week x3; Refill x _____
	<input type="checkbox"/> NuvaRing #1: sig: Insert ring vaginally x3 weeks; Refill x _____
	<input type="checkbox"/> Plan B #2 Tabs <input type="checkbox"/> (2) tabs PO now <input type="checkbox"/> Prophylactic PRN w/in 120 hrs unprotected IC Refill x _____ <input type="checkbox"/> COCs for EC _____ <input type="checkbox"/> POPs for EC _____
Return to health center <input type="checkbox"/> PRN and annually <input type="checkbox"/> Other	

Licensed Qualified Health Care Provider

Date



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