

### HORMONAL CONTRACEPTION WITH OPTIONAL PHYSICAL EXAM

▶ When did your last period start?      /      /     

▶ Was it a normal period for you?  Yes  No

Please answer the following questions by placing a mark in the "Y" column for yes, or in the "N" for no.

Y	N	
		▶ Have you had unprotected sex since your last period?
		▶ Have your periods been abnormal or irregular lately? Please describe:
		▶ Do you have any symptoms of vaginal infection? Please describe:
		▶ Are you concerned you may have been exposed to any STIs?
		▶ Are you concerned you may be pregnant?
		▶ Are you currently breastfeeding?

	Date	Where?	Normal?
▶ When was your last annual exam?			<input type="checkbox"/> Yes <input type="checkbox"/> No
▶ When was your last Pap smear?			<input type="checkbox"/> Yes <input type="checkbox"/> No
▶ When was your last breast exam?			<input type="checkbox"/> Yes <input type="checkbox"/> No
▶ When was your last mammogram?			<input type="checkbox"/> Yes <input type="checkbox"/> No

▶ Patient Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Notes: \_\_\_\_\_

O: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

HSPT(as indicated):  Positive  Negative

Teaching: <18  Abstinence Discussed  Family Involvement Discussed

Hope CIIC Given  Importance of Annual Exam

STI/HIV/Condom info given  Encouraged smoking cessation

All Methods brochure given

Back-up Method

Chlamydia (via urine test)  Accepts  Declines

CIIC given:  COC  DMPA  ECPs  Patch  POPs  Ring

Desired Method:  Method teaching done including warning signs

**Staff signature**

PFSH OF      /      /      reviewed:  No changes  Updated/annotated

A:

Y	N	
		Any C/S to progestin-only contraception?
		Any C/S to CHC?
		Any special conditions?
		Referral for further medical evaluation?

Reason to start BC method without exam at this time: \_\_\_\_\_

**Plan:** Rx: BCM **Start method:** BUM x     

ECP:  Levonorgestrel 1.5 mg po prn X     

PT:  Given  RTC  NA

Return to clinic:  6 months  Other: \_\_\_\_\_  Labs discussed

Comments: \_\_\_\_\_

Patient seen, chart and Hx reviewed

Clinician Signature: \_\_\_\_\_ Date:      /      /     

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_ DOB:      /      /      Age: \_\_\_\_\_ Date:      /      /