

PREGNANCY DETERMINATION AND OPTIONS COUNSELING

The first day of my last period was: ____ / ____ / ____

This period was: Normal Heavier Lighter
It lasted _____ days

Have you had intercourse since your last period? Yes No
If yes, when? _____

Were you using birth control or protection? Yes No
If yes, what type? _____

Do you want to be pregnant now? Yes No Unsure

Have you had a pregnancy test recently? Yes No
If yes, date it was done and result: _____

Are you breastfeeding now? Yes No

Check all symptoms you have had recently, list when they started

Abdominal pain/cramping * Started: _____

Unusual Vaginal discharge Started: _____

Shoulder pain * Started: _____

Bleeding / Spotting since your last period * Started: _____

Severe Nausea / vomiting * Started: _____

PREGNANCY HISTORY	
How many?	Dates
Live births:	Abortions:
Living children:	Stillbirths:
Miscarriages:	Tubal pregnancies:

MEDICATION HISTORY

List all medications/vitamins/herbs/supplements you take regularly or have recently taken: _____

Do you have any concerns about their effects on a potential pregnancy? Yes No
If yes, please explain: _____

Allergies: _____

HEALTH HABITS AND SOCIAL HISTORY					
Y	N		Y	N	
		Smoke cigarettes ___ packs per day For how long? _____			Emotional/ relationship problems
		Other tobacco use? If yes, for how long? _____			Someone hits, slaps, kicks, or hurts you
		Drink alcohol If yes, _____ per day/week # _____ per day OR # _____ per week			Afraid of your partner(s) / family / others?
		Social / street drugs; if yes type: # _____ per day OR # _____ per week			Sexual abuse in past; if yes, at what age? _____
		Depression? <input type="checkbox"/> Current OR <input type="checkbox"/> Past			Does someone force you to have sex?
					Other: _____

Patient Signature: _____

Notes: _____

Patient Name: _____

Chart #: _____ DOB: _____ Age: _____ Date: _____