

# PREGNANCY DETERMINATION AND OPTIONS COUNSELING

Check all symptoms you have had recently. list when they started	
My periods usually come every ____ days and last ____ days	<input type="checkbox"/> Nausea/vomiting Started: _____
The first day of my last period was: / /	<input type="checkbox"/> Tiredness Started: _____
This period was: <input type="checkbox"/> Normal <input type="checkbox"/> Heavier <input type="checkbox"/> Lighter	<input type="checkbox"/> Frequent urination Started: _____
It lasted ____ days	<input type="checkbox"/> Abdominal pain/cramping* Started: _____
Have you had intercourse since your last period? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast tenderness Started: _____
If yes, when?	<input type="checkbox"/> Vaginal discharge* Started: _____
Were you using birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Shoulder pain* Started: _____
If yes, what type?	<input type="checkbox"/> Spotting since your last period Started: _____
Do you want to be pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Other: Started: _____
Have you had a pregnancy test recently? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: Started: _____
If yes, date it was done and result:	<input type="checkbox"/> Other: Started: _____

Please check off all birth control methods you've used and the reason for stopping them:			
Reason stopped	Currently using	Reason stopped	Currently using
<input type="checkbox"/> Birth control pills	<input type="checkbox"/>	<input type="checkbox"/> Patch	<input type="checkbox"/>
<input type="checkbox"/> Depo-Provera	<input type="checkbox"/>	<input type="checkbox"/> Ring	<input type="checkbox"/>
<input type="checkbox"/> Condoms	<input type="checkbox"/>	<input type="checkbox"/> Rhythm (Natural Method)	<input type="checkbox"/>
<input type="checkbox"/> Cream/jelly/suppository	<input type="checkbox"/>	<input type="checkbox"/> Sponge	<input type="checkbox"/>
<input type="checkbox"/> Diaphragm/cervical cap	<input type="checkbox"/>	<input type="checkbox"/> Withdrawal	<input type="checkbox"/>
<input type="checkbox"/> IUD	<input type="checkbox"/>	<input type="checkbox"/> Other:	<input type="checkbox"/>
<input type="checkbox"/> Norplant	<input type="checkbox"/>		

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

ALLERGY/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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain: _____	
Allergies: _____	

HEALTH HABITS AND SOCIAL HISTORY					
Y	N		Y	N	
		Do you smoke cigarettes? For how long? _____			Depression?
		How many? ____ per day or ____ packs per day			Emotional/ relationship problems
		Other tobacco use? If yes, for how long? _____			Someone hits, slaps, kicks, or hurts you
		How much? _____ per day			Afraid of your partner(s), family, others
		Drink alcohol If yes, ____ per day/week			Sexual abuse in past; if yes, at what age? _____
		Social/street drugs; if yes, type: _____			Does someone force you to have sex?
		Amount per day/week: _____			Other: _____

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

Patient Signature: \_\_\_\_\_

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

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

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