

HORMONAL CONTRACEPTION WITH OPTIONAL PHYSICAL EXAM

▶ When did your last period start? _____ / _____ / _____			
▶ Was it a normal period for you? <input type="checkbox"/> Yes <input type="checkbox"/> 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):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Teaching:	<18 <input type="checkbox"/> Abstinence Discussed <input type="checkbox"/> Family Involvement Discussed		
	<input type="checkbox"/> Hope CIIC Given	<input type="checkbox"/> Importance of Annual Exam	
	<input type="checkbox"/> STI/HIV/Condom info given	<input type="checkbox"/> Encouraged smoking cessation	
	<input type="checkbox"/> All Methods brochure given		
	<input type="checkbox"/> Back-up Method		
	<input type="checkbox"/> Chlamydia (via urine test)	<input type="checkbox"/> Accepts <input type="checkbox"/> Declines	
CIIC given:	<input type="checkbox"/> COC <input type="checkbox"/> DMPA <input type="checkbox"/> ECPs <input type="checkbox"/> Patch <input type="checkbox"/> POPs <input type="checkbox"/> Ring		
Desired Method:	<input type="checkbox"/> Method teaching done including warning signs		
Staff signature			
PFOSH OF _____ / _____ / _____ reviewed: <input type="checkbox"/> No changes <input type="checkbox"/> 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 _____
	Plan B: <input type="checkbox"/> (2) tabs PO now <input type="checkbox"/> prn x		
	PT: <input type="checkbox"/> Given <input type="checkbox"/> RTC <input type="checkbox"/> NA		
	Return to clinic: <input type="checkbox"/> 6 months <input type="checkbox"/> Other:	<input type="checkbox"/> Labs discussed	
Comments:			
Clinician Signature: _____			Date: _____ / _____ / _____

Name: _____

Chart #: _____ DOB: _____ / _____ / _____ Age: _____

Date: _____ / _____ / _____