

Pregnancy Test Visit

Patient Label

Today's Date: ____ / ____ / ____ Age: _____ Family Doctor: _____

Limited English Proficiency? yes no Interpreter _____

Please complete all the inquires below by checking the box (✓) and/or describing all that apply.

Is the only reason for your visit today to obtain a pregnancy test? <input type="checkbox"/> yes <input type="checkbox"/> no If no, what is the other reason(s) for your visit? _____		
Reproductive Life Plan: Do you want more children? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how many more children do you want to have and when? _____ Are you currently planning a pregnancy? <input type="checkbox"/> yes <input type="checkbox"/> no If no, what are you currently using to prevent pregnancy? _____		
What was the 1 st day of your last menstrual period? _____	Are your periods regular? <input type="checkbox"/> yes <input type="checkbox"/> no	
Are you having any problems or symptoms today that you would like to discuss? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, please briefly explain:		
Are you allergic to any medicines or foods? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:		
Current medications: <input type="checkbox"/> None <input type="checkbox"/> Multivitamins <input type="checkbox"/> Calcium <input type="checkbox"/> Birth Control: Has there been a break in your method? <input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> Other: <i>(please list)</i>
Nutrition: check foods you eat every day <input type="checkbox"/> Milk / Dairy <input type="checkbox"/> Meats <input type="checkbox"/> Vegetables <input type="checkbox"/> Fruits <input type="checkbox"/> Breads or Grains	Do you have concerns about your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise <input type="checkbox"/> None <input type="checkbox"/> Seldom <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent
Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff) <input type="checkbox"/> Never used <input type="checkbox"/> Exposed to smoke <input type="checkbox"/> Past user: type _____ <input type="checkbox"/> Use now: type _____ (# per day _____)	How often do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 x per month <input type="checkbox"/> 2-4x a week <input type="checkbox"/> >4x a week How many drinks containing alcohol do you typically have when you are drinking? <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 or more	How often in the past year have you used an illegal drug (includes use of prescription medication not prescribed to you)? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 x per month <input type="checkbox"/> 2-4x a week <input type="checkbox"/> >4x a week List illegal drugs used: _____
Mental Health: <i>(in past 90 days)</i> <input type="checkbox"/> No Problem <input type="checkbox"/> Mild/Moderate Depression <input type="checkbox"/> Severe Depression <input type="checkbox"/> Thoughts of harming self / others		
Dental Health <input type="checkbox"/> Brush daily <input type="checkbox"/> Floss daily <input type="checkbox"/> Visit dentist every 6 months		
Abuse / Neglect / Violence: <input type="checkbox"/> Fear of verbal/physical abuse <input type="checkbox"/> Daily needs not met <input type="checkbox"/> Pressure to have sex <input type="checkbox"/> Forced sexual contact <input type="checkbox"/> Sex for money or drugs <input type="checkbox"/> No fear of harm		
Do you use condoms to protect against sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been treated for a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply. <input type="checkbox"/> Chlamydia; when? _____ <input type="checkbox"/> Gonorrhea; when? _____ <input type="checkbox"/> Herpes; when? _____ <input type="checkbox"/> Syphilis; when? _____ <input type="checkbox"/> HIV/AIDS; when? _____ <input type="checkbox"/> HPV/Genital Warts; when? _____ <input type="checkbox"/> Other: _____ when? _____		
Patient Signature: _____		Date: _____
Reviewed by Healthcare Provider: _____		Date: _____

THIS PAGE TO BE COMPLETED BY HEALTHCARE PROVIDER

General Appearance: Normal EDC (pos. pregnancy test) _____

Abuse, Neglect, Violence: Is there a risk of exploitation? Yes No If yes, explain _____
(sexually active minors only) Age of partner: _____

Testing today: GC Chlamydia VDRL HIV Urine PT / UCG: Positive Negative
 Other: _____

Negative Pregnancy Test Result

Health Education provided today:
Preconception Health: STD Prevention/Testing Physical activity Diet/Nutrition Alcohol/other drugs counseling
 Tobacco cessation (including 1-800-QUIT-NOW) Pelvic/ Pap Safety Mental Health Dental
 Lead exposure (ACH-25a)
Adolescent Counseling: Consent and sexual coercion Abstinence (Sexual Risk Avoidance) Benefits of parental involvement
Family Planning: Reproductive Life Plan Contraception Options FPEM-19 provided to client

Medications/Supplies: ECP
 Contraceptive: _____ Condoms issued (#) : _____
Other: _____ Client declined

Referrals: Local Family Planning provider: _____ Social Services
 1-800-QUIT-NOW Freedom from Smoking Other _____

Positive Pregnancy Test Result

Referrals & Education provided today (RNs, APRNs and other staff): EDC _____
 Prenatal Provider _____ Prenatal Program
 List of local providers provided
 DCBS Presumptive Eligibility WIC HANDS Tobacco cessation (including 1-800-QUIT-NOW) Safety
 Social Services _____
 List of pregnancy-related resources provided

Pregnancy Counseling (only APRN or higher level provider) :
 Prenatal Care Social services including Adoption Resources STD Prevention/Testing Physical activity Diet/Nutrition
 Alcohol/other drugs counseling Tobacco/vaping cessation (including 1-800-QUIT-NOW) Pelvic/ Pap Safety
 Mental Health Dental Lead exposure (ACH-25a)
Adolescent Counseling: Consent and sexual coercion Abstinence (Sexual Risk Avoidance) Benefits of parental involvement
 Other: _____

Medications/Supplies:
 Condoms issued (#) : _____
Other: _____ Client declined

Healthcare Provider Signature: _____ Date: _____