

Pregnancy Test

Date: _____

Name: _____ Age: _____ Date of Birth _____ File #: _____

All information is confidential and will not be released without your written consent, unless required by law. All clients under the age of 18 are encouraged to talk with their parents about contraception/options.

1. Do you think you may be pregnant? Yes No

2. What was the date of your last normal period? _____

3. Was your last period on time? Yes No

Was the amount of bleeding normal? Yes No

Are your periods usually regular? Yes No

Any bleeding/spotting if you missed your last period? Yes No

4. Have you had intercourse since your last period? Yes No

Within the past 5 days? Yes No

Did you use birth control? Yes No

(What method) _____

5. Have you had any of the following?

| | | | | | |
|-------------------------------|-----|----|--|-----|----|
| Nausea and/or vomiting | Yes | No | Abdominal cramping | Yes | No |
| Breast fullness or tenderness | Yes | No | Back pain | Yes | No |
| Frequent urination | Yes | No | Abdominal pain (one or both sides that radiates) | Yes | No |
| Unusually tired | Yes | No | Vaginal bleeding and spotting | Yes | No |

6. Are you currently using a method of birth control regularly? Yes No

(What kind) _____

7. History

List any current or continuing medical problems: _____

List ANY medications you take regularly: _____

Do you smoke? Yes (Amount per day) _____ No

Do you drink alcohol? Yes (Amount per day) _____ No

Do you use illegal drugs? Yes No

Have you had a shot to prevent Rubella (German Measles)(MMR)? _____

Have you been pregnant before? Yes No

Have you ever had a tubal pregnancy? Yes No

Have you ever had Gonorrhea or Chlamydia STIs Yes No

8. Is this: (Optional)

A planned pregnancy Yes No

Unplanned, but ok Yes No

Upsetting Yes No

I hereby attest that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

For Clinic Use Only

Counseling

Pregnancy Test Results _____ EDC _____

Negative Results

Teaching:

Family Planning Services
Preconceptual Education

Further Service Needs:

Family Planning
Private OB/GYN

Physical exam appointment: Offered _____ Declined _____ Will call _____ Scheduled _____

Positive Results (Options Counseling)

Teaching:

Early Prenatal
Adoption/Foster Care
Termination

Further Service Needs:

MIHP
DHS
Private OB/GYN
WIC

_____ Client was counseled regarding the importance of physical exam and early prenatal care preferably within 15 days .

Physical exam appointment Offered _____ Declined _____ Will call _____ Scheduled _____

Additional Comments: _____

I witness the fact that the client received the above information, was given the opportunity to ask questions, and understood the information.

Reviewed: _____ Date: _____