

## CONTRACEPTIVE RENEWAL FORM

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

This section to be completed by patient: Please fill in the blank or circle your answer.

Age \_\_\_\_\_ Drug allergies: NO YES, please list \_\_\_\_\_

Name of current type of contraceptive \_\_\_\_\_

Length of time you have used it? \_\_\_\_\_

Are you happy with it? YES NO If not, why? \_\_\_\_\_

Have you used other types/brands of contraceptives? YES NO  
if yes, what brand names have you used? \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ Were the results normal? YES NO

Pap was done by: \_\_\_\_\_ Will you return there? YES NO

At what age did your periods began? \_\_\_\_\_ When was your last period: \_\_\_\_\_

Were they regular before you began using contraceptives? YES NO

Do you smoke cigarettes? NO YES

If yes, How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you take other medications, herbs or vitamins: NO YES, please list below

Do YOU have a history of:

Is there a family history?

Abnormal pelvic exam	YES _____	NO _____	YES _____	NO _____
Anemia	YES _____	NO _____	YES _____	NO _____
Asthma	YES _____	NO _____	YES _____	NO _____
Blood clots	YES _____	NO _____	YES _____	NO _____
Breast lumps	YES _____	NO _____	YES _____	NO _____
Cancer	YES _____	NO _____	YES _____	NO _____
Depression	YES _____	NO _____	YES _____	NO _____
Diabetes	YES _____	NO _____	YES _____	NO _____
Epilepsy	YES _____	NO _____	YES _____	NO _____
Heart disease	YES _____	NO _____	YES _____	NO _____
High blood pressure	YES _____	NO _____	YES _____	NO _____
High cholesterol	YES _____	NO _____	YES _____	NO _____
Inflamed leg veins	YES _____	NO _____	YES _____	NO _____
Kidney disease	YES _____	NO _____	YES _____	NO _____
Liver disease or jaundice	YES _____	NO _____	YES _____	NO _____
Pelvic infections, PID, STDs	YES _____	NO _____	YES _____	NO _____
Severe headaches	YES _____	NO _____	YES _____	NO _____
Stroke	YES _____	NO _____	YES _____	NO _____
Thyroid disease	YES _____	NO _____	YES _____	NO _____
Unexplained vaginal bleeding	YES _____	NO _____	YES _____	NO _____
Weight gain _____ #	YES _____	NO _____	YES _____	NO _____
Other medical problem	YES _____	NO _____	YES _____	NO _____

Thank you. The rest of the form is for the nursing and medical staff to complete.

B/P \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

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

Contraceptives prescribed: \_\_\_\_\_

MD/NP Signature: \_\_\_\_\_ Date: \_\_\_\_\_