

FAMILY PLANNING CLINIC – Pregnancy Testing Form

Date \_\_\_\_\_

MENSTRUAL HISTORY

First day of last menstrual period \_\_\_\_\_ Was it Light \_\_\_\_\_ Medium \_\_\_\_\_ Heavy \_\_\_\_\_

Was this a normal period? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had: (Check all that apply) Nausea? \_\_\_\_\_ Increased Urination? \_\_\_\_\_  
Sleepy/Tiredness? \_\_\_\_\_ Breast Tenderness? \_\_\_\_\_

CONTRACEPTIVE HISTORY

Are you currently using a birth control method? Yes \_\_\_\_\_ No \_\_\_\_\_

If you are currently using a birth control method, what is it? \_\_\_\_\_

Have you ever missed periods previously? Yes \_\_\_\_\_ No \_\_\_\_\_

Did you recently stop a birth control method? Yes \_\_\_\_\_ No \_\_\_\_\_

Number of sexual partners in the last 6 months? \_\_\_\_\_ Last year? \_\_\_\_\_

Sex of partners? Male \_\_\_\_\_ Female \_\_\_\_\_ Both \_\_\_\_\_

PREGNANCY HISTORY

Have you ever been pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Total number of pregnancies? \_\_\_\_\_

Date last pregnancy ended? (Birth, miscarriage, abortion) \_\_\_\_\_

_____ # of live births	_____ # 1 <sup>st</sup> trimester abortions (0-12 wks)
_____ # of children still living	_____ # 2 <sup>nd</sup> trimester abortions (12-20 wks)
_____ # of C-sections	_____ # ectopic pregnancies (tubal)
_____ # of stillborn deliveries	_____ # of miscarriages

CLIENT SIGNATURE: \_\_\_\_\_

FOR CLINIC USE ONLY \*\*\*\*\* DO NOT WRITE BELOW THIS LINE \*\*\*\*\*

Urine pregnancy test results: Positive \_\_\_\_\_ Negative \_\_\_\_\_ Undetermined \_\_\_\_\_

If positive, expected date of delivery \_\_\_\_\_

Negative Results:

Scheduled appointment for Family Planning Clinic? Yes \_\_\_\_\_ Not needed/refused \_\_\_\_\_

Barrier method provided? Yes \_\_\_\_\_ Not needed/refused \_\_\_\_\_

Counseling:

WIC \_\_\_\_\_ CAO Clinic \_\_\_\_\_ Private OB/GYN \_\_\_\_\_ Comb. program app. \_\_\_\_\_ Has Medicaid \_\_\_\_\_

Sexually Transmitted Diseases \_\_\_\_\_ Prenatal Care & Delivery \_\_\_\_\_

Condom use for STD Prevention \_\_\_\_\_ Nutrition/Exercise information \_\_\_\_\_

Birth Control options \_\_\_\_\_ Danger of Alcohol/Tobacco/Drug use \_\_\_\_\_

Number of sexual partners \_\_\_\_\_ Danger of exposure to x-rays \_\_\_\_\_

Pregnancy termination info \_\_\_\_\_ Prenatal/post-partum visits \_\_\_\_\_

Infant care/Foster care/Adoption info \_\_\_\_\_ Danger/signs of miscarriage \_\_\_\_\_

All options counseling refused? \_\_\_\_\_ Pt will parent the child? Yes \_\_\_\_\_ No \_\_\_\_\_

Pre-pregnancy/Folic acid handout given? \_\_\_\_\_ Proof of pregnancy given? \_\_\_\_\_

Sheet with referral numbers given? \_\_\_\_\_

Staff comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Counselor's signature \_\_\_\_\_ Date \_\_\_\_\_

# CONSENT FOR PREGNANCY TESTING

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

I hereby request the Portsmouth City Health Department Family Planning Clinic to test my urine for pregnancy. I understand that the earlier the test, the greater the chance of error, and that the test results should be confirmed by physical examination. I further understand that the correctness of the results of the urine test is not guaranteed whether positive or negative.

Requesting a less sensitive urine pregnancy test, I understand that I should have a pelvic examination within 10 days of the test if I am considering abortion or within 30 days of the test if I am considering prenatal care. If any problems should arise, I should contact a physician or the emergency room immediately.

I hereby release the Portsmouth City Health Department Family Planning Clinic and its medical staff and employees from any and all liability arising out of or connected with this pregnancy test, and particularly with regard to any errors in diagnosis based on this test.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor's signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize and grant permission to the Portsmouth City Health Department Family Planning Clinic to release, provide, and admonish to my physician or CAO Clinic information and records concerning my pregnancy test results.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor's signature \_\_\_\_\_ Date \_\_\_\_\_