Birth Control Care Center
Compassionate Healthcare for Women

Medical History

Patient Name _____ Age _____ Date _____

How many times have you been pregnant, including this time? _____

Please indicate below how your previous pregnancies ended.

# of live births _____ # of miscarriages _____ # of abortions _____ # of c-sections _____

Have you ever had an ectopic or tubal pregnancy? ☐ Yes ☐ No

Have you ever had complications after childbirth, abortion, or miscarriage, including excessive bleeding?

☐ Yes ☐ No explain _____

When did your last menstrual period start? _____ Was it a normal period? ☐ Yes ☐ No

Have you had any bleeding since your last period? ☐ Yes ☐ No

What birth control methods have you tried? _____

Please list any operations that you have had including c-sections, D&C's, and procedures on your cervix:

_____

Have you ever had an operation to burn or freeze the lining of your uterus to stop your periods? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medications and type of reaction below:

_____

Are you allergic to latex? ☐ Yes ☐ No

Are you currently on any medications? ☐ Yes ☐ No If yes, please list them below:

_____

Do you use any recreational drugs such as cocaine, heroin, methamphetamine, etc.? ☐ Yes ☐ No

If yes, which drug(s)? _____ When did you last use? _____

Do you smoke? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

Please check if you have, or have had any of the following?

- ☐ Reaction to iodine
- ☐ Reaction to novacaine or other anesthetics
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding tendencies
- ☐ Blood transfusions
- ☐ Blood clots in your legs or lungs
- ☐ Breast lumps or tumors
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ Mitral valve prolapse
- ☐ Psychiatric illness
- ☐ Seizures or epilepsy
- ☐ Pelvic inflammatory disease (PID)
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital warts
- ☐ Herpes
- ☐ Syphilis
- ☐ Other _____

I certify that the information I have provided is true, correct, and complete.

Patient signature _____ Date _____

ROS _____

☐ History reviewed with patient

Physician signature _____ Date _____