UNIVERSITY OF MARY WASHINGTON

Lee Hall, Suite 112
1301 College Avenue
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BIRTH CONTROL QUESTIONNAIRE

(Previsit)

Student Health Center
Telephone: (540)654-1040
Fax: (540)654-1077
www.umw.edu/healthcenter

Instructions

If you are interested in starting or renewing birth control at the University of Mary Washington's Student Health Center (SHC), please do the following:

- **Answer the questions** on this form by one of the following methods:
  - Type directly on this editable PDF…OR…
  - Print the form and complete with a pen
- **Send the form to the Health Center** by one of the following methods:
  - Bring the printed form to the SHC during regular business hours… OR…
  - Mail the printed form to the SHC
- **A nurse will review the form and contact you** to schedule an appointment.
- **Please educate yourself at our website** on the "Women's Clinic" page.

If you think you need Plan B emergency contraceptive,
please make an appointment with the nurse by calling the Health Center @ 540-654-1040

Name: _____ **Birthdate:** ____/____/____ **Age:** _____

Date: ____/____/____ **Current Medications:** _____

PERIOD/MENSTRUAL HISTORY:

First day of my last period: ____/____/____

Have you had unprotected sex (without a condom or other form of birth control) since your last period?
____Yes ____No

If yes, approximate date of unprotected sex: ____/____/____

My periods come about every _____ days. My periods usually last _____ days.

My flow is**: Scanty** ____ **Moderate** ____ **Heavy** ____ **Painful** ____

I began having menstrual periods at age _____.

I have / have had irregular periods: Yes____ No____

I have severe menstrual cramps: Yes____ No____

Do you have or have you ever had any of the following (please check all that apply):

____Heart disease____Blood clots ____High blood pressure ____Gallbladder problems
____Diabetes ____Chest pain ____Liver problems ____Breast cancer
____Sexually Transmitted Infections (STI's) ____Stroke or paralysis ____Abnormal Pap Smear
____Infection in tubes, ovaries, or uterus ____Female or abdominal surgery
____Severe headaches with blurred vision, nausea, or dizziness

Explain any answers checked:

_____

_____

Do you have any significant medical conditions or health problems: Yes____ No____

If yes, explain: _____

_____

Has a close relative ever had unexplained blood clots in the legs or lungs? Yes____ No____

If yes, please explain: _____

_____

Do you smoke cigarettes? Yes____ No____

If yes, how many per day? ____

BIRTH CONTROL (check all that apply):

I have never had sex____ I am sexually active____ I have a new sex partner____

Age of first intercourse____Number of sex partners to date_____How long with present partner_____

Pregnancies:

Have you ever been pregnant: Yes____ No____ Do you think you are pregnant: Yes____ No____

Have you been pregnant in the last month: Yes____ No____

Have you ever had a Pap test? Yes____ No____

If yes, approximate date____/____/____ and results (normal or abnormal):

_____

Have you ever used any type of birth control before, including condoms? Yes____ No____

If yes, please explain: _____

_____

Have you ever taken Emergency Contraception such as Plan B? Yes____ No____

If yes, please list the date(s): _____

Do you have any concerns or questions? Yes____ No____

If yes, please explain:

_____

_____

_____

**Please be advised that neither the confidentiality nor the immediacy of electronic mail can be assured. Therefore, electronic mail should not be used to convey clinically sensitive or urgent information. This email/document, and any attachment, is intended solely for the designated recipient. If it has reached you in error, please contact the Sender.*

Name: _____ Date: ____/____/____

Signature: _____

A nurse will contact you to make an appointment. How would you like to be contacted?

Phone number: _____ Email: _____

This section for office use

Nurse/NP/MD Signature (reviewed by): _____ Date Reviewed: ____/____/____

Person contacted to call SHC and make appointment: _____