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____
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: ___________________________