

This medical record is **confidential** and will not be released to anyone except as may be required by law.

St. Croix County DHHS-Public Health Dept.

Date _____

Reproductive Health

1752 Dorset Lane, New Richmond, WI 54017

Client # _____

715-246-8365 Fax 715-246-8298

PREGNANCY HEALTH HISTORY

Name _____ Date of Birth ____/____/____ Age _____
Last First M

Please circle if you are allergic to: **No Allergies**
Penicillin Iodine Zithromax Doxycycline Sulfa Metal Rocephin
Tetracycline Latex Local anesthetic Amoxicillin Other _____

List medications, vitamins, over-the-counter drugs, and/or herbs you take: _____

REASON FOR YOUR VISIT –PREGNANCY TESTING:

Are you planning a pregnancy at this time? Yes No
If you are pregnant, will you feel? Happy Not sure Sad Worried Other: _____
If you are pregnant, do you want information on: (circle) Insurance/BadgerCare Plus Nutrition (WIC) Prenatal care
Parenting Adoption Abortion

If your pregnancy test is negative:
Do you want a method of birth control? Yes No What kind? _____
Do you want emergency contraception/condoms? Yes No
Do you want a physical exam? Yes No
Do you want preconceptional planning? Yes No

MENSTRUAL HISTORY

When was the 1st day of your last period: ____/____/____ Was it Normal? Yes No
Have you had sex since your last period? Yes No When: _____
Since your last period, have you had any of the following?: (circle all that apply)
breast tenderness fatigue increased urination nausea or vomiting pain in your lower abdomen

SEXUAL HISTORY

Age of first intercourse: _____
Have you had a new sex partner in the last 90 days? Yes No
Has your partner had a different sex partner in the last 90 days? Yes No Don't know
Circle if you have: vaginal sex oral sex anal sex sex with men sex with women sex with both

PREGNANCY

How many times have you been pregnant? _____
Dates when your pregnancy(ies) ended: _____
Have you ever had an ectopic (tubal) pregnancy? Yes No
Are you currently breastfeeding? Yes No
Do you plan to breastfeed? Yes No

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? Yes No
How many children do you hope to have? _____
How long do you plan to wait until you (next) become pregnant? _____
What do you plan to do until you are ready to get pregnant? _____

CONTRACEPTION:

Are you currently using a birth control method? No Yes, what kind: _____
When did you last use birth control: _____

SOCIAL HISTORY

Do you smoke? No Yes ____ # per day. Do you want to quit No Yes
Do you drink alcohol? No Yes Do you use street drugs? No Yes
Does alcohol/drugs cause problems in your life and/or are others concerned? No Yes
Do you feel threatened or afraid of someone in your life? No Yes
Do you have any concerns about: Date rape Forced/unwanted sex Physical abuse Weight
Do you have a health care provider if you are pregnant? No Yes
If yes, name & clinic: _____
Have you ever received medical care/medications for your mental health? No Yes

To the best of my knowledge, the above information is complete and accurate and I request a pregnancy test.