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 ______
Date last pregnancy ended? (Birth, miscarriage, abortion)
# of live births
# of young children still living
# of C-sections
# of stillborn deliveries
Total number of pregnancies? ______
# of 2nd trimester abortions (12-20 wks)
# of ectopic pregnancies (tubal)
# 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 ______
Condom use for STD Prevention ______
Birth Control options ______
Number of sexual partners ______
Pregnancy termination info ______
Infant care/Foster care/Adoption info ______
All options counseling refused? ______
Pre-pregnancy/Folic acid handout 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 ________________