

Quinacrine Sterilization History & Physical

Date: ___/___/___ Staff Initials: _____

Patient Name: Last: _____, First: _____ DOB: ___/___/___

Circle any conditions below:

Family History: **M** **F** **B** **S** **GM** **GF**

1. Blood clotting problems or bleeding tendencies: _____
2. a) Uterine abnormalities or b) Ovarian cancer: _____
3. a) Psoriasis b) Porphyria c) G6PD: _____
4. Colon or breast cancer: _____

Personal History:

1. Any in 1-4 above. Explain: _____
Allergies: _____
2. Severe STD causing PID (Chlamydia, G.C. etc.): _____
HIV tested? Y | N
3. Ectopic pregnancy: Y | N
4. a) Uterine septum/malformation or trouble with an IUD: _____
b) Uterine or cervical surgery: Y | N
c) IUD now/ever? Y | N Type: _____
5. Liver trouble such as with hepatitis C or alcoholism: _____
6. a) Anemia or steroid therapy: _____
b) Lupus, rheumatoid arthritis, or other immune system disease: _____
7. Migraine, fainting spells, seizures, "shingles" or herpes: _____
8. Diabetes, heart trouble or high blood pressure: _____
9. a) Sexual problems: _____
b) multiple sexual partners: _____
c) "bad" vaginal discharge: _____
d) abnormal Pap smear report: _____
10. Smoking? Y | N: ___ ppd x ___ years
11. List all drugs now taking & for what conditions: _____
12. Past or present substance abuse? (Confidential): _____

Menstrual History

Age periods started: _____
1st day last period: _____
Periods are:
Regular ___ Irregular ___
Painful: Y | N
Flow: Light ___ Heavy ___ Normal ___
Periods last: ___ Days

Birth Control Now? Y | N
Method: _____

Pregnancy History

Pregnancies (total): _____

Live births: _____
Abortions: _____
Miscarriages: _____
Tubal pregnancy: _____

Think you are pregnant? Y | N
Plan to have more children? Y | N

Physical Exam/Lab

Weight: _____
Height: _____
Blood Pressure: _____
Pulse: _____
Heart/Lungs: _____
Abdomen/Legs: _____
Pelvic: _____

hgb: ___ gms b-hcg: ___
ua: S ___ P ___ A ___ ua micro:

