

Client Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Chart#: \_\_\_\_\_

### **PREGNANCY TESTING INFORMATION**

A pregnancy test may not be completely accurate. Other procedures like a pelvic exam or ultrasound may be needed to accurately diagnose pregnancy or other medical conditions.

A negative pregnancy test can mean you are not pregnant, or that it is too early for pregnancy to be detected by a test at this time. The test may need to be repeated later to be sure you are not pregnant.

A physical exam is recommended as a follow-up to a positive pregnancy test to identify how long you have been pregnant, regardless of your plans with this pregnancy. If bleeding, abdominal pain or other problems occur, you should see a health care provider right away.

Please understand a pregnancy test today may not completely rule out pregnancy, and that you will receive recommendations for follow-up as needed.

### **COUNSELING AVAILABLE**

Our clinic strives to provide complete, unbiased pregnancy options counseling. Our clinic can provide you with information on the following options:

Please check any you would like more information on:

- Prenatal care and delivery
- Infant care, foster care, or adoption
- Pregnancy termination

If your test is negative, you may want information on birth control options or fertility. Please check those you want to discuss today:

- Birth control options
- Planning for Pregnancy
- Emergency Contraception
- Sexually Transmitted Infection Counseling
- Other counseling: \_\_\_\_\_
- None

## PREGNANCY TEST HEALTH HISTORY

The first day of your last normal menstrual period? (or cycle): \_\_\_\_\_

Previous menstrual period? (or cycle): \_\_\_\_\_

Was your last menstrual cycle normal? Yes No

Are you certain about that date? Yes No

How many days are there usually from the start of one period to the start of the next? \_\_\_\_\_

Does that vary more than 5 days? Yes No

Have you had sex without using birth control or condoms since your last period? Yes No

If yes, when? \_\_\_\_\_

Are you planning a pregnancy? Yes No

If yes, how long have you been trying to get pregnant? \_\_\_\_\_

Are you experiencing any relationship or partner violence? Yes No

Have you noticed any of these symptoms?

Nausea, vomiting Yes No

Swelling of the abdomen Yes No

Frequent urination Yes No

Backache Yes No

Fatigue Yes No

Breast tenderness or swelling Yes No

Other: \_\_\_\_\_

Since you suspected you might be pregnant, have you had any cramping, bleeding or spotting?

Yes No

Were you using any type of birth control when you might have become pregnant? Yes No

If yes, what? \_\_\_\_\_

Are you still using this method? Yes No

Total number of previous pregnancies		Number of live births	
Date when first pregnancy ended		Number of miscarriages	
Date when last pregnancy ended		Number of induced abortions	
Number of living children			

1. Have you had any problems with a prior pregnancy? \*(Ectopic pregnancy, pregnancy loss, preterm pregnancy, infant with a medical condition?) Yes No

2. Do you have any chronic health conditions? (Diabetes, Hypertension?) Yes No

If yes, what? \_\_\_\_\_

3. Are you taking any daily (maintenance) medications?

Please list them: \_\_\_\_\_

Note: If you checked YES to any of the above and there is a concern, a provider may contact you to discuss this history further, and consider the need for a referral.

Type: \_\_\_\_\_ Lot # \_\_\_\_\_ Expiration: \_\_\_\_\_ Results:  Positive  Negative

Signature of person doing the test \_\_\_\_\_ Date \_\_\_\_\_

- Negative Pregnancy Test**
- Reproductive Life Plan
  - Investigate reasons for delayed menses (elaborate below)
  - Birth Control Methods/EC
  - Preconception
  - Infertility Services
  - Domestic Violence/Abuse
  - Alcohol, Tobacco, Recreational Drugs Use
  - OTC medications and Prescription Medications
  - Nutrition/Folic Acid 0.4 mg
  - STI/HIV Counseling/Testing
  - Adolescents: Abstinence, Family Involvement, Sexual Coercion
  - Rx for Plan B (2) tablets now, PRN UPI Refills \_\_\_\_\_
  - Rx for Ella (if BMI>26)
  - EC Dispensed
  - Retest On \_\_\_\_\_
  - Counseled on available services and recommended screening tests.

- Positive Pregnancy Test**
- Reproductive Life Plan
  - Support system (family, friends, clergy)
  - Prenatal Care (ACOG recommends first visit at 8-10 weeks gestation)
  - Adoption/Foster care/Infant care
  - Termination
  - Intimate Partner Violence/Domestic Violence
  - Alcohol, Tobacco, Recreational Drug Use
  - OTC medications and Prescription Medications
  - Nutrition/Folic Acid 0.4 mg
  - Ectopic Warnings
  - STI/HIV Counseling/Testing
  - Adolescents: Abstinence, Family Involvement, Sexual Coercion
  - Counseled on available services and recommended screening tests including first trimester genetic testing.

Comments/Referrals:

Provider Contacted  
Provider Name: \_\_\_\_\_  
Date Contacted: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Provider Recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No Need for Provider Follow-up

Signature (Staff giving results): \_\_\_\_\_  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_