

FAMILY PLANNING ORAL CONTRACEPTIVE  
INITIATION RECORD

Name \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
**Allergies** \_\_\_\_\_  
Current Method of Contraception \_\_\_\_\_  
Current Medications \_\_\_\_\_  
LNMP \_\_\_\_\_ Last sexual intercourse \_\_\_\_\_

**History**

Current known pregnancy or suspected pregnancy  yes  no  
Currently breastfeeding  yes  no  
Unexplained vaginal bleeding  yes  no  
Cigarette smoker age 35 or older  yes  no  
Headaches with focal neurological symptoms and/or aura  yes  no  
Known or suspected breast cancer or history thereof  yes  no  
Hypertension (>140/90 mm Hg) or history thereof  yes  no  
Diabetes mellitus (vascular disease or >20 yrs duration)  yes  no  
Current thromboembolic disease or history thereof  yes  no  
Cerebrovascular or coronary artery disease or history thereof  yes  no  
Hepatic disease (tumors, hepatitis, cirrhosis)  yes  no  
Cancer of the endometrium (or estrogen dependent tumor)  yes  no

BP \_\_\_\_\_ **Urine Pregnancy Test** (if indicated)  pos  neg

Date \_\_\_\_\_ **Interpreter Name** \_\_\_\_\_

**Staff Signature** \_\_\_\_\_

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**Clinician Comments** \_\_\_\_\_

**Assessment** Combined oral contraception candidate  yes  no

**Contraception Plan**

- Plan B  offered  given
- Condoms  offered  given
- Combined oral contraceptive initiated brand name \_\_\_\_\_  
# of cycles \_\_\_\_\_ start date \_\_\_\_\_
- Other method of contraception initiated/continued/restarted \_\_\_\_\_

**Return Visit** \_\_\_\_\_

Date \_\_\_\_\_ **Interpreter Name** \_\_\_\_\_

**Clinician Signature** \_\_\_\_\_