University of Mary Washington
Student Health Center
1301 College Avenue
Lee Hall, Suite 112
Fredericksburg, VA 22401
540-654-1040 (office) 540-654-1077 (FAX)
Website: www.umw.edu/cas/healthcenter

Birth Control Questionnaire

previsit

Instructions

If you are interested in starting or renewing birth control at the University of Mary Washington's Student Health Center (SHC), please do the following:

- **Answer the questions** on this form by one of the following methods:
  - Type directly on this editable PDF … OR …
  - Print the form and complete with a pen.
- **Send the form to the Health Center** by one of the following methods:
  - Bring the printed form to the SHC during regular business hours … OR …
  - Mail the printed form to the SHC … OR …
  - Email your request and the electronically completed form as an attachment to UMWWomensClinic@gmail.com.
- **A nurse will review the form and contact you** to schedule an appointment.
- **Please educate yourself at our website** at the following link on the "Women's Clinic" page.
  - Women's Video
  - Emergency Contraception
  - Who shouldn't take the pill?
  - STI Testing
  - Gardasil
  - Pregnancy Testing

If you think you need Plan B emergency contraceptive,
please make an appointment with the nurse by calling the Health Center at 540-654-1040.

Questions

1. **How old are you?** _____ _____

2. **If you are sexually active, at what age did you have your first intercourse?** _____ ☐ N/A

3. **What type of birth control would you like the SHC to help you with?** Choose one:
   ☐ Birth control pills ☐ Birth control patch (OrthoEvra) ☐ Vaginal ring (NuvaRing)
   ☐ Injection (DepoProvera) ☐ Diaphragm ☐ IUD ☐ Mirena ☐ Other _____

4. **Have you ever used any type of birth control before, including condoms?** ☐ No ☐ Yes
   If yes, please explain: _____

5. **Have you ever had problems using birth control in the past?** ☐ No ☐ Yes
   If yes, please explain: _____

6. **Do you have or have you ever had any of the following medical conditions?**
   ☐ Heart disease ☐ Blood clots ☐ High blood pressure ☐ Gallbladder problems
   ☐ Diabetes ☐ Chest pain ☐ Liver problems
   If yes, please explain: _____

7. **Has a close relative ever had unexplained blood clots in the legs or lungs?** ☐ No ☐ Yes
   If yes, please explain: _____

8. **Do you have or have ever had breast cancer?** ☐ No ☐ Yes
   If yes, please explain: _____

9. **Do you often get severe headaches with blurred vision, nausea or dizziness?** ☐ No ☐ Yes
   If yes, please explain: _____

10. **Do you smoke cigarettes?** ☐ No ☐ Yes
    If yes, how many per day? _____

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11. **Do you think you are pregnant?** ☐ No ☐ Yes
12. **Have you been pregnant in the past month?** ☐ No ☐ Yes
13. **What is the date of your last menstrual period (first day of your last period)?** _____
14. **Have you had unprotected sex (without a condom or other form of birth control) since your last period?** ☐ No ☐ Yes
    If yes, approximate date of unprotected sex: _____
15. **Have you had unexplained vaginal bleeding in the past 2 months?** ☐ No ☐ Yes
    If yes, please explain: _____
16. **Are you planning surgery that will keep you from walking for a week of more?** ☐ No ☐ Yes
    If yes, please explain: _____
17. **Do you have severe acne?** ☐ No ☐ Yes
18. **Do you have severe menstrual cramps?** ☐ No ☐ Yes
19. **Have you ever had a Pap test?** ☐ No ☐ Yes
    If yes, approximate date _____and results (normal or abnormal:
    _____
20. **Please list current medications:** _____
21. **Do you have any significant medical conditions or health problems?** ☐ No ☐ Yes
    If yes, please explain: _____
22. **Do you have any concerns or questions?** ☐ No ☐ Yes
    If yes, please explain: _____

Comments: _____

_____

_____

Name: _____ Date: _____

Signature: _____ (sign before mailing or at the time of your visit if emailed)

A nurse will contact you in 1-2 business days. How would you like to be contacted?

❑ Call me ❑ Text me Phone Number: _____
If you prefer texting, we need to know your phone provider:
❑ AT&T ❑ Verizon ❑ Sprint ❑ Nextel ❑ T-Mobile ❑ Boost Mobile ❑ Other _____

❑ E-mail me at this address: _____

This section for office use

Nurse/NP/MD Signature: _____ Date Reviewed: _____

☐ Appointment scheduled for: _____