#EHKÄISYNETTI

Your background information, for choosing contraception

www.ehkaisynetti.fi

Name:	Social security number:
Address:	Tel:

General health

Height:	Weight:
BMI: (nurse fills in)	Blood pressure: (nurse fills in)

Allergies: ○ no ○ yes, what:

Diagnosed with focal migraine: ○ no ○ yes

Acne: ○ no ○ yes

Diabetes: ○ no ○ yes

Depression, fatigue: ○ no ○ yes

Eating disorders: ○ no ○ yes

Would you like to get nutrition counseling, help for weight control: ○ no ○ yes

Intoxicants

Smoking, age at starting: cigarettes/day:

Alcohol use: how often:

how many servings:

Experimenting with/using drugs: ○ no ○ yes

Sexuality and relationship

Are you dating someone? ○ in relationship ○ single

Would you like to talk about sexuality with a healthcare professional? ○ no ○ yes

Have you experienced sexual abuse? ○ no ○ yes

Family history

Has someone in your immediate family (parent or siblings) had any of the following when under 50 years of age?

Venous or pulmonary blood clots:	○ yes	○ no	Known susceptibility to blood clots or bleedings:	○ yes	○ no
Stroke:	○ yes	○ no	Breast cancer:	○ yes	○ no

Gynecological history

When did you first get your period: age:

Starting date of last periods:

Menstrual cycle

○ regular (normal 21–35 days)

○ irregular

Menstrual bleeding

○ light ○ usual ○ heavy

Duration of menstrual bleeding: days

Menstruation pain

○ no ○ mild ○ strong

Medication for menstruation pain:

Bleeding disorders: ○ no ○ breakthrough bleeding

Earlier **deliveries (year):**

miscarriages (year):

abortions (year):

Pap smear: ○ yes, last time (year):

○ no

Sexually transmitted diseases: ○ no ○ yes, what _____

Use of emergency contraception: ○ yes, _____ times/year ○ no

Do your examine your breasts regularly: ○ yes ○ no

Contraception

Current contraception: How long have you used it: How long will you need contraception?

Does your current contraceptive method have side effects, such as

Headache:	○ yes	○ no	Vaginal dryness:	○ yes	○ no
Do you have headaches during the break week?	○ yes	○ no	Nausea:	○ yes	○ no
Breast swelling/discomfort:	○ yes	○ no	Greasiness of the skin, acne:	○ yes	○ no
Swelling elsewhere in the body:	○ yes	○ no	Spotting:	○ yes	○ no
Weight gain:	○ yes	○ no	Sweating symptoms (”hot flushes”):	○ yes	○ no
Blood pressure increased:	○ yes	○ no	Vaginal infections (yeast):	○ yes	○ no
Loss of sexual appetite:	○ yes	○ no	Wishes for contraception:		
Mood swings:	○ yes	○ no			

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