

EHKÄISYN HOITOPOLKU

Suomen Nuorisolääkärit ry

MEDICAL HISTORY CONCERNING

HORMONAL CONTRACEPTION

Name		Date of birth			
GENERAL HEALTH CONDITION					
	YES	NO	SPECIFY		
Long term diseases					
Regular medication					
Visual or sensory migraine with aura					
Skin problems (e.g.acne)					
Allergies					
DISEASES OF CLOSE RELATIVES (siblings and parents)					
	YES	NO	Don't know	SPECIFY (who, what, at what age)	
Coagulation factor gene disorder					
Venous thrombosis (e.g. pulmonary embolism)					
Cerebrovascular disorder					
Coronary artery disease/cardiac infarction					
Breast cancer					
Do you have or have you had any of these conditions?					
SMOKING/ALCOHOL/DRUGS					
	YES	NO	SPECIFY (quality/amount/frequency)		
Smoking			amount of cigarettes	day/week/month	
Alcohol			amount of dosages	day/week/month	
Drugs			specify	day/week/month	
MENSTRUATION					
Menstruation started at age			Date the last period started		
Length of the cycle*			Bleeding duration (days)		
Period cramps	None	Mild	Quite strong	Strong	Need help!
Do you use pain killers for menstrual cramps? Specify name, frequency and dosage.					
* Count days from the first bleeding day to the first bleeding day of the next menses					

PREVIOUS CONTRACEPTION			
	YES	NO	SPECIFY (name, suitability, length of usage, side effects)
Previous hormonal contraception			
Emergency contraception			times used: _____ last date: _____
SEXUAL HEALTH INFORMATION			
	YES	NO	SPECIFY
Have you ever had sexual intercourse? If NO , skip the following numbered rows			Age at the time of the first sexual intercourse: Number of partners:
1. Pregnancies			When
2. Deliveries			When
3. Miscarriages			When
4. Abortions			When
5. Sexually transmitted diseases			Which and when
6. Test for STDs taken			Which and when
Gynaecological diseases			Specify
HPV vaccination			Year
Pap smear taken			Date and result
Gynaecological examination			When
Genital area problems/symptoms			Specify
Do you know how to examine your breasts?			
OTHER ISSUES			
	YES	NO	SPECIFY
Experiences of sexual harassment or violence?			
Any other concerns regarding contraception, sex or sexuality?			
EXAMINATION BY PUBLIC HEALTH NURSE			
Height	Weight		BMI
			Blood pressure