

Tufts University Health Service
Birth Control Information Form
Must be Completed Prior to Visit

Name: _____ Date: _____

Medical History:

Have you or anyone in your family ever had:	You	Family
➤ Hospitalization or Operation	<input type="checkbox"/>	
➤ Blood Clot in Leg or Lung	<input type="checkbox"/>	<input type="checkbox"/>
➤ Breast Mass, Cancer or Problem	<input type="checkbox"/>	<input type="checkbox"/>
➤ Depression	<input type="checkbox"/>	<input type="checkbox"/>
➤ Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
➤ Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
➤ Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
➤ Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
➤ High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
➤ High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
➤ Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
➤ Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Gynecologic History

	Yes	No
➤ Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
○ If yes, for how long? _____		
➤ Are you currently using a method of birth control?	<input type="checkbox"/>	<input type="checkbox"/>
○ If yes, what? _____		
○ Are you happy with your current method?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you ever had a gyn examination?	<input type="checkbox"/>	<input type="checkbox"/>
○ If yes, when was your last one? _____		
➤ Have you ever had an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you ever had an STI (Sexually Transmitted Infection)	<input type="checkbox"/>	<input type="checkbox"/>
○ If yes, what & when? _____		