PREGNANCY TEST RECORD

Patient Name: ______________________________ **DOB:** __________ **Age:** _______ **Today's Date:** ______________

First Day of Last Menstrual Period	Was it normal? ☐ Yes ☐ No	Have you already performed a home test? ☐ Yes ☐ No Results: ____________________

Which method (s) of Birth Control used:

- ☐ Birth Control Pill
- ☐ Hormonal Ring
- ☐ Hormonal Patch
- ☐ Plan B
- ☐ IUD
- ☐ Male Condom
- ☐ Vaginal Spermicide
- ☐ Other____________________________________
- ☐ FABM
- ☐ Depo Provera Shot
- ☐ Implant
- ☐ Vasectomy
- ☐ Tubal Ligation
- ☐ Female Condom
- ☐ Diaphragm
- ☐ Withdrawal

Symptoms:

- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Fatigue
- ☐ Urinary Frequency
- ☐ Missed Period
- ☐ Breast Tenderness
- ☐ Other_________________
- ☐

Number of Pregnancies	Number of Miscarriages/Abortions	Number of Deliveries	Number of Living Children

Do you use the following?	Do you desire a pregnancy now?	Plans if Pregnant
Tobacco ☐ Yes ☐ No Alcohol ☐ Yes ☐ No Street Drugs ☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure Plans if Not Pregnant	☐ Parenting ☐ Adoption ☐ Termination ☐ Unsure

Medications (prescriptions, non-prescriptions, diet supplements, herbs/vitamins)

Do you have allergies? ☐ Yes ☐ No	If Yes, Explain

Pregnancy Test Results ☐ Negative ☐ Positive	EDC	Estimation of Gestational Age

PLANS

Positive Results: (Information provided on)

- ☐ Adoption
- ☐ Avoidance of Drugs/Alcohol/Tobacco
- ☐ Avoidance of X-ray Exposure
- ☐ Medications/Health Conditions
- ☐ Nutrition
- ☐ Pregnancy Options
- ☐ Family Support System
- ☐ Prenatal Care
- ☐ Prenatal Vitamins
- ☐ SAB/Ectopic precautions
- ☐ Zika / Q fever precautions
- ☐ STD/HIV testing/prevention

Negative Results: (Information provided on)

- ☐ FP Services
- ☐ Infertility Services
- ☐ Preconception Counseling
- ☐ Reproductive Life Plan
- ☐ When to repeat test
- ☐ Safer Sex Practices
- ☐ Delayed/Missed menses
- ☐ Declines FP Services

Referred For:

- ☐ Adoption Counseling/Services
- ☐ Alcohol/Drug/Tobacco Cessation
- ☐ Infertility Services
- ☐ Maternal & Child Health
- ☐ Prenatal Care
- ☐ Social Services
- ☐ STD Testing
- ☐ WIC/Nutrition
- ☐ Other ________________

Adolescent Counseling:

- ☐ Abstinence
- ☐ Parental involvement
- ☐ Sexual coercion