



SUBJECTIVE DATA (complete the top section)

First Day of Last Menstrual Period	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Most Recent Method(s) of Birth Control Used	
Symptoms:			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Complexion Changes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bloating	<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Vaginal Bleeding	
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?	
Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	Street Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
		Plans if Pregnant	
		<input type="checkbox"/> Parenting <input type="checkbox"/> Adoption <input type="checkbox"/> Termination <input type="checkbox"/> Unsure	
		Plans if Not Pregnant	
Medications (prescriptions, non-prescriptions, diet supplements, herbs/vitamins)			
Do you have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Explain	

OBJECTIVE DATA (Staff Use)

Pregnancy Test Results <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Urine Sample <input type="checkbox"/> 1st Morning <input type="checkbox"/> Voided at Visit	EDC
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If positive, client counseled that pelvic confirmation be performed as soon as possible, preferably within 15 days _____ (initial)

PLANS

Positive Results: (Information provided on)		
<input type="checkbox"/> Pregnancy Test Verification	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Foster Care
<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Avoidance of Drugs/Alcohol/Tobacco	<input type="checkbox"/> Pregnancy Termination
<input type="checkbox"/> Prenatal Vitamins	<input type="checkbox"/> Avoidance of X-ray Exposure	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Adoption	
Negative Pregnancy Tests: (Information provided on)		
<input type="checkbox"/> FP Services (Birth control methods, ECP's)	<input type="checkbox"/> Safer Sex Practices	<input type="checkbox"/> Infertility Services
Referred For:		
<input type="checkbox"/> Pregnancy Confirmation	<input type="checkbox"/> Adoption Counseling/Services	<input type="checkbox"/> Alcohol/Drug/Tobacco Cessation
<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Foster Care Counseling/Services	<input type="checkbox"/> STD Testing
<input type="checkbox"/> OPOP/Baby Steps	<input type="checkbox"/> Pregnancy Termination	<input type="checkbox"/> Infertility Services
<input type="checkbox"/> WIC	Counseling/Services	<input type="checkbox"/> Other _____
<input type="checkbox"/> Social Services	<input type="checkbox"/> WIC	

Addressed Required Adolescent Counseling (parental involvement and avoidance of sexual concern): _____ (initial)

Comments: _____

Staff Signature	Date	
Name	Birth Date	Chart Number