IUD/IUS INSERTION: PATIENT HISTORY

How old are you? _____ years

Have you ever been pregnant? ☐ Yes ☐ No

How many children do you have, if any? ____ N/A

How many miscarriages have you had, if any? ____ N/A

How many abortions have you had, if any? ____ N/A

How many ectopic pregnancies have you had, if any? ____ N/A

Have you ever had a C-section? ☐ Yes ☐ No

What was the date of your last period (first day)? _________ (yy/mm/dd)

Was it a normal period for you? ☐ Yes ☐ No

How long is your menstrual cycle in general?
(Count from the first day of period to the first day of next period) ______ days

When was your last PAP test done? _________ (yy/mm/dd)
☐ Unknown ☐ I have never had one done

For a post-partum insertion, what was the date of your delivery? _________ (yy/mm/dd)

For a post-partum insertion, are you breastfeeding? ☐ Yes ☐ No

Did you have sexual intercourse since your last period? ☐ Yes ☐ No

Are you consistently (each and every time) using condoms?
Or an effective method of birth control (e.g. pills) since your
Last period or during the last month? ☐ Yes ☐ No

What was the date of your last sexual intercourse? _________ (yy/mm/dd)

If you already use an intrauterine device, what kind is it?
☐ Mirena® ☐ Kyleena®
☐ Jaydess ® ☐ Copper
☐ Other ☐ N/A

For how many years has your current IUD been in place? ____________

What contraceptive method are you currently using, if anything? ____________

Have you had an infection of the uterus or the tubes in the last
3 months? (Vaginitis does not exclude insertion) ☐ Yes ☐ No

Have you had vaginal bleeding between your periods or short menstrual cycle (less than 21 days between periods) during the last year? ☐ Yes ☐ No

Did a physician ever tell you that you have cervical cancer? ☐ Yes ☐ No

Have you ever had treatment for a precancerous cervical lesion? ☐ Yes ☐ No

Did a physician ever tell you that you had endometrial cancer? (cancer of the inside of the uterus) ☐ Yes ☐ No

To your knowledge, is your uterus of normal shape? ☐ Yes ☐ No

Did a physician tell you that you have or had fibroids? ☐ Yes ☐ No

Have you ever had a sexually transmitted disease (STD)? ☐ Yes ☐ No
If yes, which infection and the year: ______________________________

Have you received treatment for this STD? ☐ Yes ☐ No

When was the last STD treatment you received? ____________ (Year)

Have you been screened for Chlamydia & Gonorrhoea during the last 2 months? ☐ Yes ☐ No

How many sexual partners have you had during the last 2 months? ____________

Do you take medications on a regular basis? If so, which ones? ☐ Yes ☐ No

____

Do you have allergies to medications or to copper? If so, please list ☐ Yes ☐ No

____

Do you need a hormonal IUS for another purpose than contraception? ☐ Yes ☐ No

____

We thank you for answering to this questionnaire. Please note that you will have to see again your clinician in 6-8 weeks in order to verify that the IUD/IUS is in the right position within the uterus. The risk of expulsion of an IUD or IUS is more frequent during the month following insertion. So, we suggest that you use condom at each sexual intercourse until the next visit. This will ensure that you are well protected against unplanned pregnancy.

Your Signature: ______________________________ Date: ______________

Clinician's Signature: ___________________________ Date: ______________