McLaren Ambulatory Care Center
IUD INSERTION

Date: ___________________________

Phone (Home): ___________________________ (Work/Cell):___________________________

Current Weight:__________ Blood Pressure: __________ Last menstrual period: ____________

HISTORY

Pregnancy: ___ Pregnancies ___ Live Births ___ Abortions ___ Miscarriages

Date of Last Delivery: ____________

Previous abnormal pap test: ❑ No or ❑ Yes Explain:________________________

History of previous cervical procedure: ❑ No or ❑ Yes Explain:________________________

History of cancer (cervical): ❑ No or ❑ Yes

Smoker: ❑ No or ❑ Yes

History of Venereal Diseases: ❑ No or ❑ Yes

Check boxes that pertain: ❑ Chlamydia ❑ Gonorrhea ❑ Herpes ❑ Syphilis ❑ HIV

Serum pregnancy test: ____________________ Pap results: ________________________

Vag culture results: _______________________ DNA GC/Chlamydia results: ____________

Uterine sound: _________________ Cm

Pelvic/Bimanual Exam (Pre-Insertion): ____

____

PROCEDURE:

Physician performing procedure

Stock Number:___________________________ Type of IUD: ________________________

PLAN

1. Patient informed of risk and complications of this procedure including, but not limited to, perforation of the uterus, infections, heavy bleeding and/or cramping. *____________
2. Discourage smoking
3. Encourage monogamous relationship. If relationship changes have cervical cultures redone. May need IUD removed
4. Yearly physical exam
5. Patient to check IUD string placement after each menstrual cycle
6. Call clinic if fever, pelvic pain, abnormal uterine bleeding or missed menses

Date of scheduled removal: __________________

Education/Risk/Benefit Discussed and Information Given * ______________

____

Patient Signature Date

____

Witness Date

____

Provider's Signature Date/Time

* INITIAL BY PATIENT COPY GIVEN TO PATIENT* ________

MM-34 (8/13)

Patient Name:

Date of Birth: