REPRODUCTIVE HEALTH AND WELLNESS LIFE PLAN

Date:

Name:	Birth Date:

Family Planning

Do you want to have children/more children? (If currently pregnant, skip to below.) □ YES □ NO

If *yes*:
- At what age would you like to have children? _____
- How many more children would you like? _____
- How far apart would you like your children to be spaced? _____
- Are you currently using some form of birth control? □ YES □ NO

If *no*:
- What birth control option would you like to consider? □ YES □ NO
- Do you currently have any children? If yes, how many? _____
- What will you do if you do become pregnant? _____

If *Pregnant*: Did you want to be pregnant now, in the future, or never? □ YES □ NO
- How many children do you plan to have? _____
- Do you plan to carry the pregnancy to term? □ YES □ NO
- Do you plan to keep the baby? □ YES □ NO
- What form of birth control would you like to consider postpartum? _____

Personal Habits

Do you use tobacco (smoke or chew)?	□ YES	□ NO
Do you drink alcohol?	□ YES	□ NO
If yes, how much? _____ How often? _____		
Do you have multiple sexual partners?	□ YES	□ NO
Do you tend to engage in unhealthy dieting or overeating?	□ YES	□ NO
Do you use recreational drugs or abuse medications?	□ YES	□ NO

Emotional Health

When you feel sad do you bounce back quickly or feel sad for 2 weeks or more? _____

How often do you feel nervous, anxious or worried? _____

How do you calm yourself down if you are angry? _____

Is there anyone in your life who is physically abusive?	□ YES	□ NO
Is there anyone in your life who often says hurtful or mean things?	□ YES	□ NO

Important Vaccinations

Please check vaccinations you have received.

- □ Gardasil / HPV
- □ Hepatitis A / Hepatitis B
- □ Inactivated Polio Virus
- □ Measles, Mumps, Rubella (German Measles)
- □ Tetanus / Pertussis (Whooping Cough)
- □ Varicella

Family History

Please check those which have occurred in immediately family (mother, father, grandparents, siblings).

- □ A baby born prematurely or weighing less than 5 ½ lbs.
- □ Asthma
- □ Baby with a heart defect
- □ Cancer
- □ Diabetes
- □ Gestational diabetes
- □ Heart or Lung Disease
- □ Hypertension
- □ Mental illness / Depression
- □ Pre-eclampsia or eclampsia
- □ Stillborn baby
- □ Stroke
- □ Two or more miscarriages

Name: Birth Date:

Personal Goals:

□ I will take a daily multivitamin or prenatal vitamin with folic acid.
□ I will start an exercise program or increase my exercise frequently.
□ I will quit smoking or reduce the amount I currently smoke.
□ I will increase or always use condoms with sexual activity.
□ I will quit or decrease the amount of alcohol or drugs I use.
□ I will increase, maintain, or reduce my weight.
□ I will not get pregnant until I am ready by abstaining from intercourse or using birth control continuously.
Other: _____

Career or Professional Goals:

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

I would like more information provided about:

□ Abuse – Emotional
□ Abuse – Physical
□ Abuse – Sexual
□ Anxiety and Stress
□ Birth Control Methods
□ Depression
□ Drug / Alcohol Abuse
□ Healthy Eating
□ Sexually Transmitted Disease
□ Signs of a Healthy Relationship
□ Smoke Cessation
□ Unhealthy Dieting/Over Eating
□ Vaccinations

_____ Date _____
Patient Signature

_____ Date _____
Reviewer Signature