

**HEALTH QUARTERS  
Pregnancy Test Assessment**

Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_

Date of the first day of your last period \_\_\_\_\_

Do you get a period once a month?       Yes    No \_\_\_\_\_

Was this last period a normal one for you?    Yes    No \_\_\_\_\_

Are you using birth control/condoms       No    Yes \_\_\_\_\_

Are you having any of these symptoms?

- Nausea/Vomiting    Breast tenderness    Abdominal pain    Bleeding/spotting

Have you done a home pregnancy test?    No    Yes result \_\_\_\_\_

Were you planning this pregnancy?       No    Yes

Have you been pregnant before?       No    Yes

Do you have children?       No    Yes \_\_\_\_\_

Are you taking any medicines?       No    Yes \_\_\_\_\_

Urine chlamydia test      Result \_\_\_\_\_

**Positive**  

- Options counseling done
- Referred for prenatal care
- Info about adoption given
- Info on healthy pregnancy/Multi vit /folic acid
- Support system/family involvement
- Referred for abortion
- HIV/STD risk assessed

**Negative**  

- Retest advised in \_\_\_\_\_
- BCM discussed
- ECP discussed    Dispensed
- Plan B prn x 1 yr \_\_\_\_\_ NP/CNM
- HIV/STD risk assessed
- Infertility referral
- Referred for eval of delayed menses
- Family involvement discussed

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff signature \_\_\_\_\_ Date \_\_\_\_\_