THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
LA SOCIÉTÉ DES OBSTÉTRICIENS ET GYNÉCOLOGUES DU CANADA

IUD/IUS INSERTION: SIMPLIFIED PATIENT HISTORY

How old are you?	_____ years
Have you ever been pregnant?	☐ Yes ☐ No
How many children do you have, if any?	_____
How many miscarriage have you had, if any?	_____
How many abortions have you had, if any?	_____
How many ectopic pregnancies have you had, if any?	_____
Have you ever had a C-section?	☐ Yes ☐ No
What was the date of your last period (first day)?	______________ Year \month\day
Was it a normal period for you?	☐ Yes ☐ No
How long is your menstrual cycle in general (count from the first day of a period to the first day of the next period)?	_____ days
For a post-partum insertion, what was the date of your last delivery?	______________ Year \month\day
For a post-partum insertion, are you breastfeeding?	☐ Yes ☐ No
Did you have sexual intercourse since your last period or during the last month?	☐ 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?	______________ Year \month\day
If you already use an intrauterine device, what kind of device is it?	☐ Copper ☐ Mirena ☐ Jaydess ☐ Other ☐ Not applicable
For how many years has your old 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 your periods) during the last year?	☐ Yes ☐ No
Did a physician ever tell you that you had a cervical cancer?	☐ Yes ☐ No
Have you ever had a treatment for a precancerous cervical lesion?	☐ Yes ☐ No
Did a physician ever tell you that you had an endometrial cancer (cancer of the inside of the uterus)?	☐ Yes ☐ No
To your knowledge, is your uterus of normal shape?	☐ Normal ☐ Abnormal ☐ I do not know
Did a physician tell you that you had a fibroid?	☐ Yes ☐ No
Did a physician ever tell you that you had breast cancer?	☐ Yes ☐ No
Have you ever had a sexually transmitted disease (STD)?	☐ Yes ☐ No
If yes, please list which infections and what year:	_____ _____ _____
Have you received treatment for this STD?	☐ Yes ☐ No
When was the last STD treatment you received? (indicate the 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 year?	_____
How many sexual partners have you had in the last 2 months?	_____
Do you take medications on a regular basis?	☐ Yes ☐ No
Which medications do you take?	_____ _____
Do you have allergies to medications or to copper?	☐ Yes ☐ No
Which medications are you allergic to?	_____ _____

Do you need a Mirena® for another purpose than contraception? ☐ Yes ☐ No

If yes, what is the purpose? _____

We thank you for answering to this questionnaire. Please note that you will have to see again your physician, your nurse practitioner or the physician at this clinic in 6-12 weeks in order to verify that the IUD or 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 this next visit. This will ensure that you are well protected against unplanned pregnancy.

Date : _____/____/_____ Your signature : _____
YYYY/MMM/DD

Date : _____/____/_____ Physician's signature: _____
YYYY/MMM/DD

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INSERTION OF AN INTRAUTERINE DEVICE OR SYSTEM – PROVIDER REPORT

CHECKLIST:

Patient Not Pregnant by History : ☐ Yes ☐ No
Pregnancy test done today : ☐ Negative ☐ Positive ☐ Not done
Consent form signed : ☐ Yes ☐ No

GYNECOLOGICAL EXAMINATION:

Vulva (S/S of STI):_____

Vagina:_____

Cervix (Pap, Swabs if Done) :_____

Bimanual exam: Uterus (Anteverted/Retroverted, Masses):_____

Adnexa (masses) :_____

Removal of IUD/IUS: ☐ Yes ☐ No Details :_____
Type IUD/IUS removed: ☐ Mirena ☐ Jaydess ☐ Other ☐ Copper, specify : _____

INSERTION

Cleansing of cervix : ☐ Yes ☐ No Details : Chlorhexidine x 2-3 _____

Anesthesia of cervix : ☐ Yes ☐ No Details : Xylocaine 1% : dose : ___ ml;
location : _____

Uterine Cavity on Sounding : _____ cm

Type of inserted IUD/IUS : ☐ Mirena ☐ Jaydess ☐ Other ☐ Copper (Type) : _____
Lot : _____ Expiration date for insertion : ____ /____ /____
Year /month/day

Threads cut at : _____ cm from the external os

Tolerated by Patient (well, mild-moderate vasovagal, etc) :_____

Adverse events : ☐ Yes ☐ No Details :_____

_____

DIAGNOSIS : Removal of IUD/IUS ☐ Yes ☐ No
Insertion of IUD/IUS ☐ Yes ☐ No

MANAGEMENT : Screening of Chlamydia/gonorrheae ☐ Done today ☐ Not done ☐ In the chart
Ultrasound (if difficult insertion) ☐ Yes ☐ No
Follow-up visit in 6-12 weeks. Use of condom at each sexual intercourse before next visit

Date : _____/____/_____ Signature : _____
Year /month/day