

Patient Consent for IUD Placement

Name: _____ Date: _____

Type of IUD requested: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Yes No Don't Know

Abnormalities of the uterus	_____	_____	_____
Acquired immune deficiency syndrome (AIDS)	_____	_____	_____
Anemia or blood clotting problems	_____	_____	_____
Bleeding between periods	_____	_____	_____
Cancer of the uterus or cervix	_____	_____	_____
History of other types of cancer	_____	_____	_____
Steroid therapy (for example, prednisone)	_____	_____	_____
Possible pregnancy	_____	_____	_____
Diabetes	_____	_____	_____
Ectopic pregnancy in the past	_____	_____	_____
Fainting attacks	_____	_____	_____
Genital sores	_____	_____	_____
Heart disease	_____	_____	_____
Heart murmur	_____	_____	_____
Heavy menstrual flow	_____	_____	_____
Hepatitis or other liver disease	_____	_____	_____
Infection fo the uterus or cervix	_____	_____	_____
IUD in place now or in the past	_____	_____	_____
IV drug abuse now or in the past	_____	_____	_____
Leukemia	_____	_____	_____
More than one sexual partner	_____	_____	_____
A sexual partner who has had more than one sexual partner	_____	_____	_____
Pelvic infection	_____	_____	_____
Abortion or miscarriage in the past 2 months	_____	_____	_____
Severe menstrual cramps	_____	_____	_____
Sexually transmitted disease (STD) such as gonorrhea or chlamydia	_____	_____	_____
Abnormal Pap smear	_____	_____	_____
Unexplained genital bleeding	_____	_____	_____
Uterine or pelvic surgery	_____	_____	_____
Vaginal discharge or infection	_____	_____	_____
HIV infection	_____	_____	_____
Breastfeeding	_____	_____	_____

I have read the IUD general information sheet and the corresponding manufacturer's specific information in its entirety. I have discussed its contents with my provider. I have completed the IUD checklist and reviewed it with my provider. My provider has answered my questions and advised me of the risks, benefits, and alternatives associated with the use of the IUD of my choice. I fully understand the explanations. I have considered all factors and voluntarily choose to have the IUD inserted by _____ (Provider's Name).

First day of last menstrual period _____ Last pap smear/pelvic exam? _____

Current method of contraception _____ Unprotected intercourse in last 14 days? yes no

Allergy to Betadine/Iodine/Shellfish? yes no Allergy to Lidocaine or Novacaine? yes no

Pre-Medicated self as instructed? yes no

Patient Signature: _____

Date: _____