University of Maryland
University Health Center

Birth Control Refill

Date ______________________ Phone/Cell Phone ______________________

Name ______________________ Allergies ______________________

Soc.Sec.# ______________________ Current Medications ______________

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Age ______________________ Date of Last PAP Smear ____________

First Day of Last Menstrual Period ________________ Result was Normal ______________ Abnormal ______________

Name of Current Birth Control ______________________________

Have you had any of the following?

	YES	NO		YES	NO
Headache	❏	❏	Missed Doses	❏	❏
Vision Problems	❏	❏	Missed Period	❏	❏
Chest Pain	❏	❏	Do you smoke?	❏	❏
Leg Pain	❏	❏	Amount ________________		
Breast Swelling/ Tenderness/Lumps	❏	❏	Bleeding other than menstrual period	❏	❏
Swollen hands or feet	❏	❏	Depression/ Moodiness	❏	❏

Details of these symptoms or any other symptoms?

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Patient Signature ____

S-

O- Weight ______________________ B/P ______________________

A-

P- Rx ____________________

RTC ____________________

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❏ Referred for Annual P/P

Provider ____

Revised 7/03