UNIVERSITY OF ILLINOIS AT SPRINGFIELD
Health Services • (217) 206-6676

Consent for Hormonal Contraception (HC) In Women with High Risk Factors

Date _____

Name of Patient _____
(please print)

UIN _____

Address _____

Date of Birth _____

Published scientific studies have indicated that there is an increased probability of developing serious circulatory disease, including heart attack, in women using hormonal contraceptives who have high-risk factors. During pregnancy, the seriousness of these risk factors is potentially greater. These risk factors include:

- Age over 35
- Smoking (more than 15 cigarettes a day)
- High Blood Pressure
- Diabetes (including a family history of diabetes parents or siblings)
- Grossly Overweight
- High Blood Fat Level (Cholesterol and/or triglycerides)
- Parental History of Early Heart Attack (under age 50)

You have been examined and interviewed regarding your medical history. The following factors, which may increase your risk of developing a serious complication while using hormonal contraceptives, were found:

_____

_____

_____

I HAVE READ THE LITERATURE CONCERNING HORMONAL CONTRACEPTIVES, THE STATEMENT ABOVE AND THE CONSENT FORM ON THE REVERSE SIDE, AND I CLEARLY UNDERSTAND THEIR MEANING.

Signature of Patient _____ Date _____

I WITNESS THE FACT THAT THE PATIENT RECEIVED, READ AND SAID SHE UNDERSTOOD THE LITERATURE, THE STATEMENT ABOVE AND THE CONSENT FORM ON THE REVERSE SIDE.

Witness _____ Date _____

REVIEWED	DATE/TEST DONE	NORMAL	ABNORMAL

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Consent for Hormonal Contraception (HC)

I have received from Health Services literature containing information on the use, effectiveness and known risks of hormonal contraceptives (HC). I understand the information, and I have chosen HC as my method of birth control.

I understand that the benefits and risks of taking HC are:

BENEFITS: Highly effective in preventing pregnancy when used properly
No special preparation necessary before intercourse
Allows women to regulate and plan monthly cycle
Usually causes a lighter menstrual flow
May minimize premenstrual tension and menstrual cramps
Chances of iron deficiency are decreased

RISKS: Major: Heart attack, blood clots, various eye disorders, stroke, aggravation of diabetes, liver tumors, changes in sex drive, high blood pressure, gall bladder disease

Minor: Nausea, weight gain or loss, vaginal infections, spotting between periods, missed periods, headaches, mood changes, acne, dark area(s) on skin

I understand that I can change my mind and stop using it if I choose; but if I do, and have intercourse without using another birth control method, I may get pregnant. I fully understand that Health Services cannot guarantee the effectiveness of the contraceptive method(s) I have chosen, and I have received no such guarantee.

I understand that it is my responsibility to ask questions about birth control and that a registered nurse or a doctor is available to answer any questions I may have. I have also been encouraged to ask questions of the Health Services staff concerning birth control. I have been assured that, after I leave the clinic, I can call 206-6676 for more information, if any medical problem should arise.

I understand that complete medical history information is important. I have been honest and complete in informing Health Service of my medical history. I will receive a pelvic exam, blood pressure determination, pap smear and urinalysis necessary for prescribing hormonal contraception. I understand that I am to return for an examination.

If at any time while I am taking my prescription, I have any of the following problems - SEVERE HEADACHES, BLURRED OR DOUBLE VISION, OR LEG, CHEST, OR ABDOMINAL PAIN - I should return to Health Services, call 206-6676, or go to an emergency room.

I HAVE READ THE LITERATURE PROVIDED AND THE STATEMENTS ABOVE, AND I UNDERSTAND THEIR MEANING. I REQUEST THAT HORMONAL CONTRACEPTION BE PRESCRIBED FOR ME.

Signature of Patient _____ Date _____

UIN _____

I WITNESS THE FACT THAT THE PATIENT RECEIVED, READ AND SAID SHE UNDERSTOOD THE INFORMATION AND THE STATEMENTS ABOVE.

Witness _____ Date _____

REVIEWED

Date	Patient's Signature	Witness's Signature

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