



Pregnancy Status

Date: _____

Patient Name: _____ DOB: ____ / ____ / ____

Male (Please proceed to the end of the document to sign in the designated area)

Female

1. Are you currently pregnant? Yes No

2. Do you still experience a regular or irregular menstrual period? Yes No

a. If NO,

⌚ Age of menopause? _____

3. Do you still have reproductive organs? Yes NO

a. If NO,

⌚ NO - I have had a complete hysterectomy (uterus and both ovaries surgically removed)
Date of complete hysterectomy? _____

⌚ NO - I have had a partial hysterectomy (one or both ovaries remaining)
Date of partial hysterectomy? _____

Patient Signature : _____

Date : _____

Provider Signature : _____

Date : _____



Pregnancy Status

Risks of Opioid Use in Pregnancy-(For Female Use Only)

There are significant risks associated with opioid use during pregnancy. Studies have shown treatments with opioid analgesics during pregnancy are linked to the following health risks:

- Known risks to the fetus:
 - Spina Bifida (a type of neural tube defect)
 - Hydrocephaly (buildup of fluid in the brain)
 - Glaucoma (an eye defect)
 - Gastroschisis (a defect of the abdominal wall)
 - Congenital Heart Defects
 - Conoventricular Septal Defect
 - Hypoplastic Left Heart Syndrome
 - Atrial Septal Defect
 - Tetralogy of Fallot
 - Pulmonary Valve Stenosis
 - Incomplete Pulmonary System Development
 - Neonatal Abstinence Syndrome
 - Low Birth Weight
- Known risks to the woman:
 - Miscarriage
 - Preterm Labor and/or Delivery
 - Categorization of High Risk Pregnancy

Please Read and Initial the Statements Below:

_____ I have read and understand the risks associated with the use of opioids during pregnancy as listed above.

_____ I understand that while being prescribed opioid medication, it is my responsibility to ensure that I am taking reasonable measures to prevent pregnancy.

_____ I agree to notify my provider with any changes in my method of birth control.

_____ I will immediately notify my provider should I become pregnant while receiving treatment.

_____ I will notify my provider should I plan to become pregnant.

Patient Signature : _____

Date : _____

Provider Signature : _____

Date : _____