IUD/IUS EVALUATION FORM

Name _____ **Agency** _____

Date of birth _____ **Type of IUD/IUS** _____

Insertion Date: _____

1. When must your IUD/IUS be removed: _____
   Month/Year
2. First day of last menstrual period? _____
3. Can you feel your IUD/IUS string? ☐ No ☐ Yes
4. Are you satisfied with your IUD/IUS? ☐ No ☐ Yes
5. Is your partner satisfied with your IUD/IUS? ☐ No ☐ Yes
6. Since your IUD/IUS was inserted, have you had any infections or sexually transmitted disease?

   ☐ No ☐ Yes ☐ Don't know
7. Check if you have any of the following:

   ☐ Cramping
   ☐ Burning with urination
   ☐ Back pain
   ☐ Unusual vaginal discharge
   ☐ Heavy bleeding with periods
   ☐ Fever
   ☐ Pain with intercourse
   ☐ Bleeding between periods
8. How often should you check for your IUD/IUS strings?

   a. Frequently
   b. After each period
   c. Anytime you have abnormal bleeding or cramping
   d. All of the above
9. You may not be protected if:

   a. You cannot feel the string
   b. You can feel the plastic
   c. The string gets longer or shorter
   d. All of the above
10. Your IUD/IUS should be removed or changed (circle all that apply):

    a. Once you reach menopause
    b. 3 months before you want a pregnancy
    c. 5 years after insertion
    d. 10 years after insertion
    e. Whenever I wish to change methods
    f. f. None of the above

Do you have any questions about the IUD/IUS? ☐ No ☐ Yes

_____

Patient signature **Date**

TO BE COMPLETED BY STAFF

S:

O:

Examination	WNL	Abn.	Comments
Ext. Genitalia			
Vagina			
Cervix			String visualized: ☐ yes ☐ no
Discharge			
Uterus			
Adnexae			

A:

P:

_____

Staff signature **Date**