

Hormonal Contraceptive Self-Screening Questionnaire

Name _____ Health Care Provider's Name _____ Date _____
 Date of Birth _____ Age* _____ Weight _____ Do you have health insurance? Yes / No
 What was the date of your last women's health clinical visit? _____
 Any Allergies to Medications? Yes / No If yes, list them here: _____

Background Information:

1	Do you think you might be pregnant now?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	What was the first day of your last menstrual period?	___/___/___
3	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Did you ever experience a bad reaction to using hormonal birth control?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, what kind of reaction occurred?	_____
	Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, which one do you use?	_____
4	Have you ever been told by a medical professional not to take hormones?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Do you smoke cigarettes?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Medical History:

6	Have you given birth within the past 6 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Are you currently breastfeeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Do you have diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Do you get migraine headaches? If so, have you ever had these kinds of headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Do you have high blood pressure , hypertension, or high cholesterol?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Have you ever had a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Have you ever been told by a medical professional that you are at risk of developing a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15	Have you had bariatric surgery or stomach reduction surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Do you have or have you ever had breast cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
18	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, list them here:	
20	Do you have any other medical problems or take any medications, including herbs or supplements?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	- If yes, list them here:	

Do you have a preferred method of birth control that you would like to use?

A pill you take each day **A patch that you change weekly** **Other (ring, injectable, implant, or IUD)**

Internal use only verified DOB* with valid photo ID BP Reading _____/_____

Pharmacist Name _____ Pharmacist Signature _____

Drug Prescribed _____ Rx# _____ -or- Patient Referred-circle reason(s)

Sig: _____ (Pharmacy Phone _____ Address _____)