Hormonal Contraceptive Self-Screening Questionnaire

Name_____ Health Care Provider's Name _____ _____

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 pregnant now?	Yes ☐ No☐
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 injection? Have you previo ly had contraceptives prescribed to you by pharmacist?	
	you ever experience a bad reaction using hormonal birth control?	
	- If yes, t kind of reaction occurred?	_____
	Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection?	
	- If yes, which one do you use?	_____
4	Have you ever been told by a medical professional not to take hormones?	
5	Do you smoke cigarettes?	

Medical History:

6	Have you given birth within the past 6 weeks?	Yes ☐ No ☐
7	Are you currently breastfeeding?	
8	Do you have diabetes?	
9	Do you get migraine headaches? If so, have you ever had the kind 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?	
10	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes ☐ No ☐
11	H you r had heart attack or stroke, or been told you had any heart disease?	
12	Have you ever had a blood clot?	
13	Have you ever been told by a medical professional that you are at risk of developing a blood clot?	
14	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	
15	ariatric surgery or stomach reduction surgery?	
16	Do you have or have you ever had breast cancer?	
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)?	
18	Do you have lupus, rheumatoid arthritis, or any blood disorders?	
19	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	
	- If yes, list them here:	
20	Do you have any other medical problems or take any medications, including herbs or pplem	
	- 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)

_____(Pharmacy Phone _____ Address _____)

Notes: _____