Hormonal Contraceptive Self-Screening Questionnaire (revised 10/2017)

Name: _____Address:_____ Date:_____

Date of Birth: _____ Age: _____ Weight: _____ Do you have health insurance? Yes / No

What was the date of your last women's health visit? _____Any Allergies to Medications? *Yes / No* If yes, list:_____

Background Information/Medical History:

1	Do you think you might be pregnant now?	Yes □ No □
2	Do you smoke cigarettes?	Yes □ No □
3	Do you have any medical problems or take any medications, including herbs or supplements? If yes, list them here:	Yes □ No □
4	Drug Interactions: do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? If yes, list them here:	Yes □ No □
5	What was the first day of your last menstrual period?	
6	Have you ever experienced any irregular pattern, heavy, or prolonged vaginal bleeding?	Yes □ No □
7	Have you ever taken birth control pills, or used a birth control patch, ring, or injection? Have you previously had contraceptives prescribed to you by a pharmacist?	Yes □ No □ Yes □ No □
8	Did you ever experience a bad reaction to using hormonal birth control? If yes, what kind of reaction occurred?	Yes □ No □
9	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?	Yes □ No □
10	Have you ever been told by a medical professional not to take hormones?	Yes □ No □

11	Have you given birth within the past 21 days? If yes, how long ago?	Yes □ No □
12	Are you currently breastfeeding?	Yes □ No □
13	Do you have diabetes?	Yes □ No □
14	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?	Yes □ No □ Yes □ No □
15	Do you have multiple risk factors for cardiovascular disease including high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes □ No □
16	Have you had a heart attack or been diagnosed with ischemic heart disease, had a stroke, or been told you have valvular heart disease?	Yes □ No □
17	Have you ever had a blood clot (deep venous thrombosis/pulmonary embolism)?	Yes □ No □
18	Have you ever been told by a medical professional that you are at risk of developing blood clots?	Yes □ No □
19	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	Yes □ No □
20	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes □ No □
21	Have you had a history of bariatric surgery or stomach reduction surgery?	Yes □ No □
22	Do you have or have you ever had breast disease or breast cancer?	Yes □ No □
23	Do you have or have you ever had viral hepatitis, liver disease, liver tumors, or gallbladder disease, or do you have jaundice (yellow skin or eyes)?	Yes □ No □
24	Do you have systemic lupus, rheumatoid arthritis, or any blood disorders?	Yes □ No □

REQUIRED: Pharmacist Measured BP Reading: _____/_____2nd BP Reading (if necessary):__/__Date BP Taken:_____Arm: ____Cuff Size: _____

Do you have a preferred method of birth control that you would like to use? □ Pill □ Patch □ Ring □ Shot □ Other_____□ Uncertain/Unsure

For internal use only

□ Drug Prescribed: _____ - or - □ Patient Referred

Sig: _____ Quantity:_____

Refills:_____RPh Name: _____ RPh Signature: _____