Contraceptive Self-Screening Questionnaire

Patient Name_____Date of Birth_____Age_____Weight_____

Health Care Provider's Name _____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_____

_____

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

□A daily pill □A weekly patch □A vaginal ring □Injectable (every 3 months) □Other (IUD, implant)

Background Information:

1	Do you think you might be 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 previously had contraceptives prescribed to you by a pharmacist?	Yes □ No □ Yes □ No □
	Did you ever experience a bad reaction to using hormonal birth control?	Yes □ No □
	- If yes, what kind of reaction occurred?	_____
	Are you currently using any method of birth control including condoms, pills, or a birth control patch, ring or shot/injection?	Yes □ No □
	- If yes, which one do you use?	_____
	- If no, when was the last time you had penis-in-vagina sex?	_____
4	Have you ever been told by a medical professional not to take hormones?	Yes □ No □
5	Do you smoke cigarettes or use other forms of tobacco?	Yes □ No □

Medical History:

6	Have you had a recent change in vaginal bleeding that worries you?	Yes □ No □
7	Have you given birth within the past 21 days? If yes, how long ago?	Yes □ No □
8	Are you currently breastfeeding?	Yes □ No □
9	Do you have diabetes?	Yes □ No □
10	Do you get migraine headaches?	Yes □ No □
10a	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 □
11	Are you being treated for inflammatory bowel disease?	Yes □ No □
12	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes □ No □
13	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes □ No □
14	Have you ever had a blood clot?	Yes □ No □
15	Have you ever been told by a medical professional you are at risk of developing a blood clot?	Yes □ No □
16	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes □ No □
17	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	Yes □ No □

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18	Have you had bariatric surgery or stomach reduction surgery?	Yes □ No □
19	Do you have or have you ever had breast cancer?	Yes □ No □
20	Have you had a solid organ transplant? (e.g. kidney, liver, intestines, heart, lung, pancreas)	Yes □ No □
21	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 □ No □
22	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes □ No □
23	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes □ No □
	- If yes, list them here:	
24	Do you have any other medical problems or take any medications, including herbs or supplements?	Yes □ No □
	- If yes, list them here:	

Pregnancy Screen	
a. Did you have a baby less than 6 months ago, are you fully or nearly-fully breast feeding, AND have you had no menstrual period since the delivery?	Yes □ No □
b. Have you had a baby in the last 4 weeks?	Yes □ No □
c. Did you have a miscarriage or abortion in the last 7 days?	Yes □ No □
d. Did your last menstrual period start within the past 7 days?	Yes □ No □
e. Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes □ No □
f. Have you been using a reliable contraceptive method consistently and correctly?	Yes □ No □

Signature _____ *Date* _____