Name: ______________________________ Date of Birth: _______/______/______

Today's Date: _______/______/_______ Phone Number: _____________

Email: ___________________________ Date of Last Provider Visit: ______________________

Primary Care/Women's Health Provider: ________________________________

Provider's Contact Information: ________________________________

## Screening Questions for Birth Control

***General Information:***

| | | |
|---|---|---|
| 1 | What was the first day of your last menstrual period? | ___/ ___/ _____ |
| 2 | What is your age? | |
| 3 | What is your weight? | |
| 4 | Do you think you might be pregnant now? | Yes □ No □ |
| 5 | Have you ever used the following medications? Please check all that apply:<br>□ Birth control pills □ Birth control shot □ Condoms<br>□ Birth control patch □ Birth control ring □ Emergency contraception /Plan B<br>□ Birth control implant/rod □ Intrauterine device (IUD) □ Other___________ | Yes □ No □ |
| a | Did you ever experience a bad reaction (side effect) to using hormonal birth control? If yes, please list what kind of reaction occurred: | Yes □ No □ |
| b | Are you currently using any method of birth control including pills, patch, ring, or shot/injection?<br>If yes, please list which method you use: | Yes □ No □ |
| 7 | Have you ever been told by a medical professional not to take birth control or other hormones? | Yes □ No □ |

***Medical History:***

| | | |
|---|---|---|
| 8 | Have you given birth within the past 6 months?If yes, date of delivery: _______________________ | Yes □ No □ |
| 9 | Are you currently breastfeeding? | Yes □ No □ |
| 10 | Do you have diabetes? | Yes □ No □ |
| 11 | Do you get migraine headaches? | Yes □ No □ |
| a | If so, have you ever had the kind of headaches that start with warning signs (aura) or symptoms such as flashes of light, blind spots, or tingling in your hands or face that come before the headache starts? | Yes □ No □ |
| 12 | Do you have either of the following? (Please check yes, even if it is controlled by medication)<br>□ High blood pressure/hypertension □ High cholesterol? | 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 (for example, a deep vein thrombosis or pulmonary embolism)? | Yes □ No □ |
| 15 | Have you ever been told by a medical professional that you are at higher risk of developing a blood clot? Examples might include antiphospholipid antibody syndrome, Factor V Leiden, or a prothrombin mutation. | Yes □ No □ |
| 16 | Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? If yes, please explain:<br>Type of Surgery:______________________________Date of Surgery:_____/____/____ | Yes □ No □ |
| 17 | Have you had bariatric surgery (weight loss) or stomach reduction surgery? | Yes □ No □ |

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| | | |
|---|---|---|
| 18 | Do you have any of the following conditions? Please check below:<br>□ Breast Cancer □ Gall bladder disease □ Multiple Sclerosis<br>□ Lupus □ Blood disorders<br>□ Rheumatoid arthritis □ Solid Organ Transplant<br>□ Inflammatory Bowel Disease (IBD)<br>□ Hepatitis, liver disease, liver cancer, or jaundice (yellow skin or eyes) | Yes □ No □ |
| a | Do you have any other medical problems?<br>- If yes, list medical problems here:________________________________________ | Yes □ No □ |
| 19 | Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? If yes, list them here: | Yes □ No □ |
| 20 | Do you take any medications, including herbs or supplements?<br>- If yes, list medications here: ____________________________________________ | Yes □ No □ |
| 21 | Do you have allergies or bad reaction to medication? If yes, please explain here:<br>_________________________________________________________________ | Yes □ No □ |
| 22 | Do you smoke cigarettes, use chewing tobacco, e-cigarettes, or other nicotine products? | Yes □ No □ |

23 What goals do you have regarding birth control (examples: help with painful periods, prevent pregnancy)?

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For the Pharmacist: If a patient has a potential contraindication or answers "Yes" to any of the Medical History questions, please consult the USMEC.

To be completed during appointment:

Date of appointment: ______/______/_________

Blood pressure: _______________ mmHg Can reasonably rule out pregnancy? Yes □No □

Prescription(s) issued: ________________________________________________________________________________

Provider notified: No provider, referral made □

Yes □ Provider/Practice: ____________________________________________________________________________

Notified via: □ Fax □ Phone □ Email □ Mail □ Other: ____________________________

Date notified: ______ / _______ / _________

Pharmacist completing appointment: _______________________________________________________