Utah Hormonal Contraceptive Self-Screening Questionnaire

Name______________________________ Health Care Provider’s Name__________________________ Date______

Date of Birth____________ Age______ (must be 18) 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 ____________________________

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

□A daily pill □A weekly patch □A monthly vaginal ring □Injectable (every 3 mo.) □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? Yes □ No □
   Have you previously received contraceptives? 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 pills, or a birth control patch, ring or shot/injection? Yes □ No □
   - If yes, which one do you use? ________________________________
4. Have you ever been told by a medical professional not to take hormones? Yes □ No □
5. Do you smoke cigarettes? 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. Have you ever had a migraine headaches? 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 □
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? 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:

Signature_______________________________________________________________________ Date______________
### Pregnancy Screen

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>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?</td>
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<td>b. Have you had a baby in the last 4 weeks?</td>
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<td>c. Did you have a miscarriage or abortion in the last 7 days?</td>
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<td>d. Did your last menstrual period start within the past 7 days?</td>
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<td>e. Have you abstained from sexual intercourse since your last menstrual period or delivery?</td>
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<td>f. Have you been using a reliable contraceptive method consistently and correctly?</td>
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**Note:** Must refer patient if either systolic or diastolic reading is out of range, per algorithm

- [ ] Verified DOB with valid photo ID
- [ ] BP Reading ______ / ______

**Directions for Use**

**Pharmacist Name** ____________________________  **Pharmacist Signature** ____________________________

**Pharmacy Address** ____________________________  **Pharmacy Phone** ____________________________

-or-

- [ ] Patient Referred

**Notes:**

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________