

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 <input type="checkbox"/> No <input type="checkbox"/>
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 received contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
	Did you ever experience a bad reaction to using hormonal birth control? - If yes, what kind of reaction occurred?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
	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 <input type="checkbox"/> No <input type="checkbox"/> _____
4	Have you ever been told by a medical professional not to take hormones?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Do you smoke cigarettes?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Medical History:

6	Have you had a recent change in vaginal bleeding that worries you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Have you given birth within the past 21 days? If yes, how long ago?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Are you currently breastfeeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Do you have diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Have you ever had a migraine headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Are you being treated for inflammatory bowel disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes <input type="checkbox"/> No <input type="checkbox"/>
13	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14	Have you ever had a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15	Have you ever been told by a medical professional you are at risk of developing a blood clot?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
18	Have you had bariatric surgery or stomach reduction surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Do you have or have you ever had breast cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
20	Have you had a solid organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
22	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
23	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? - If yes, list them here:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
24	Do you have any other medical problems or take any medications, including herbs or supplements? - If yes, list them here:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____

Signature _____ Date _____

Optional Side – May be used by pharmacy

This side of form may be customized by pharmacy –Do not make edits to the Questionnaire (front side)

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 <input type="checkbox"/>	No <input type="checkbox"/>
b. Have you had a baby in the last 4 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Did you have a miscarriage or abortion in the last 7 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. Did your last menstrual period start within the past 7 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e. Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f. Have you been using a reliable contraceptive method consistently and correctly?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Verified DOB with valid photo ID BP Reading _____ / _____

Note: Must refer patient if either systolic or diastolic reading is out of range, per algorithm

Rx Drug Prescribed _____ Rx _____
Directions for Use _____
Pharmacist Name _____ Pharmacist Signature _____
Pharmacy Address _____ Pharmacy Phone _____

-or-

Patient Referred

Notes:

Please Fill out form and email to: Creek.rx@gmail.com