# 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?<br>Have you previously received contraceptives? | Yes □ No □<br>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*______________

*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 □ 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 □ |

☐ Verified DOB with valid photo ID ☐ BP Reading ______ /_______

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

℞ Drug Prescribed ______________________________________________________Rx_______________________
Directions for Use ______________________________________________________________________________
Pharmacist Name ______________________________ Pharmacist Signature ___________________________
Pharmacy Address ____________________________________ Pharmacy Phone ________________________

-or-

☐ Patient Referred

Notes:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________