BIRTH CONTROL SCREENING FORM

This information is strictly confidential.

Name:	**Date of birth**: _____ / _____ / _____	**Today's date**: _____ / _____ / _____
Email:		**Phone:**
Primary care or women's health provider:	**Provider's contact info:**	

A summary of today's visit will be sent to your provider, if you agree. ☐ Yes ☐ No ☐ No provider

First date of your last menstrual period: _____ / _____ / _____	**Date of your last STD/HIV tests:** _____ / _____ / _____	**Date of your last reproductive health clinical visit:** _____ / _____ / _____

Birth control method(s) you are currently using:
☐ Pills ☐ Patch ☐ Ring ☐ Shot ☐ Condoms ☐ Other(s): _____

Birth control method(s) you would like at this visit:
☐ Pills ☐ Patch ☐ Ring ☐ Shot ☐ Condoms ☐ Other(s): _____

ALLERGIES (List name of each medicine and your reaction to it)

BIRTH CONTROL HISTORY (List each birth control type and your experience with it)

HEALTH HISTORY

Have you had a **hysterectomy**?	☐ Yes ☐ No
Have you had **unprotected sex** in the last 5 days?	☐ Yes ☐ No
Do you think you might be **pregnant** now?	☐ Yes ☐ No
Have you **abstained from sex or used a reliable form of birth control** since your last period?	☐ Yes ☐ No
Have you had a **miscarriage or abortion** in the last 7 days?	☐ Yes ☐ No
Have you **given birth** within the last 6 months?	☐ Yes ☐ No
Are you currently **breastfeeding** a baby?	☐ Yes ☐ No
Do you smoke **cigarettes**?	☐ Yes ☐ No
Do you have or have you ever had **breast cancer**?	☐ Yes ☐ No
Have you ever been told by a medical professional not to take **hormones**?	☐ Yes ☐ No
Do you have **vaginal bleeding** for an unknown reason?	☐ Yes ☐ No

Do you have **migraine headaches**, or headaches so bad that you feel sick to your stomach, you lose the ability to see, it makes it hard to be in light, or it involves numbness?	☐ Yes ☐ No
Have you had **bariatric surgery** or stomach reduction surgery?	☐ Yes ☐ No
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
Do you have **diabetes**?	☐ Yes ☐ No
Do you have **high blood pressure, hypertension,** or **high cholesterol**?	☐ Yes ☐ No
Have you ever had a **heart attack** or **stroke**, or been told you had any **heart disease**?	☐ Yes ☐ No
Have you ever had a **blood clot** in your leg or in your lung?	☐ Yes ☐ No
Have you ever been told by a medical professional that you are at a high risk of developing a **blood clot** in your leg or in your lung?	☐ Yes ☐ No
Have you had recent major **surgery** or are you planning to have surgery in the next 4 weeks?	☐ Yes ☐ No
Do you have **lupus, rheumatoid arthritis,** or any **blood disorders**?	☐ Yes ☐ No
Do you take **medication for seizures, tuberculosis,** or **human immunodeficiency virus (HIV)**? If yes, list them here:	☐ Yes ☐ No
Do you have any other **medical problems** or take **any other medications**, including herbs or supplements? If yes, list them here:	☐ Yes ☐ No

I am requesting a birth control consultation and prescription from the pharmacist. I understand the following:

- The pharmacist is providing care based on the information I provide.
- If the pharmacist is unable to provide my desired method of birth control, I will be given a referral to another healthcare provider.
- No method of birth control is 100% effective at preventing pregnancy.
- Hormonal birth control does not start working right away to prevent pregnancy. After using hormonal birth control for 7 days, it will prevent pregnancy.
- Hormonal birth control does not protect against sexually transmitted diseases (STDs). Condoms protect against STDs.
- The pharmacist will review my birth control options. For my selected birth control method, the pharmacist will review how to use it and what to expect. The pharmacist is available to answer all my questions.
- I will contact my pharmacist, primary care provider or women's health provider regarding any side effects, problems, or changes to my health status or medications.
- It is advised to have regular visits with a primary care or other reproductive health provider to receive recommended tests and screenings.

Signature: _____ Date: _____ / _____ / _____