HORMONAL CONTRACEPTIVE RISK ASSESSMENT
QUESTIONNAIRE FOR PATIENT COMPLETION

Note to patient: Complete this questionnaire and bring to your pharmacy for self-administered hormonal contraceptives. You should call your pharmacy first to make certain the pharmacy is able to provide this service. You may also obtain the questionnaire from participating pharmacies.

Patient Name: ..... Date: .....

Date of Birth: ..... Age: ..... Weight: ..... Height: .....

Email address: ..... Telephone Number: .....

What was the date of your last women's health clinical visit? ___/___/___
Any allergies to medications? Yes □ No □
If yes, list them here:
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Do you have a preferred method of birth control you would like to use?
A daily pill □ A weekly patch □ A monthly vaginal ring □ Injectable (every 3 months) □

1	Do you think you could be pregnant now?	Yes □	No □
2	What was the starting date of your last menstrual period? _____/_____/_____		
3	Have you ever taken birth control pills or used a birth control patch, ring, shot, or injection?	Yes □	No □
	- If yes, have you previously had contraceptives dispensed to you by a pharmacist?	Yes □	No □
4	Have you ever experienced a bad reaction to using hormonal birth control?	Yes □	No □
	- If yes, what kind of reaction occurred?		
5	Are you currently using birth control pills or a birth control patch, ring, shot, or injection?	Yes □	No □
6	Have you ever been told by a medical professional not to take hormones?	Yes □	No □
7	Do you smoke cigarettes?	Yes □	No □
8	Have you had a recent change in vaginal bleeding that worries you?	Yes □	No □
9	Have you given birth within the past 21 days?	Yes □	No □
	- If yes, what was the date of the birth? _____/_____/_____		

10	Are you currently breastfeeding?	Yes □	No □
11	Do you have diabetes?	Yes □	No □
12	Do you get migraine headaches?	Yes □	No □
	- If yes, have you ever had headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that goes completely away before the headache starts?	Yes □	No □
13	Do you have high blook pressure, hypertension, or high cholesterol? (Please indicate yes even if your hypertension is controlled by medication.)	Yes □	No □
14	Have you ever had a heart attack or stroke, or been told by a medical professional you have heart disease?	Yes □	No □
15	Have you ever had a blood clot?	Yes □	No □
16	Have you ever been told by a medical professional you are at a high risk of developing a blood clot?	Yes □	No □
17	Have you ever had bariatric surgery or stomach reduction surgery?	Yes □	No □
18	Have you had a recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes □	No □
19	Do you plan to have restricted mobility for a long period of time? (e.g. a long airplane trip, etc.)	Yes □	No □
20	Do you have or have you ever had breast cancer?	Yes □	No □
21	Do you have or have you ever had hepatitis, 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 the medications here:		
24	Do you have any other medical problems or take regular medication(s)?	Yes □	No □
	- If yes, list problems or medications here:		
25	Do you take any herbal or vitamin supplements?	Yes □	No □
	- If yes, list supplements here:		

Patient Signature: ..... Date: .....

Reviewing Pharmacist Signature: ..... Date: .....