Birth Control Questionnaire

Date:_____Patient's Name:_____Date of Birth:_____

Address:_____

_____Phone Number:_____

Primary Care Physician (name and number): _____

When was the last time you had a well women's health visit?_____

Do you have health insurance?(circle one) Yes / No If Yes, please have card ready to give to pharmacist.

Medication:

Please list name/strength of all medications you take (prescription, over the counter, and supplements):

1.	4.
2.	5.
3.	6.

Medication Allergies:

1.	2.

1.Background Information:	
1. Do you think you might be pregnant?*	☐ Yes ☐ No
2. What was the last day of your last menstrual period?*	/ /
3. Have you previously had contraceptive prescribed by a pharmacist?*	☐ Yes ☐ No
4. Have you ever taken birth control pills or used a birth control patch or injection? *If yes, please list the name:	☐ Yes ☐ No
5. Are you currently taking birth control pills or a birth control patch or injection? * If yes, please list the name:	☐ Yes ☐ No
6. Did you ever experience a bad reaction to hormonal birth control?* If yes, what was the reaction:	☐ Yes ☐ No
7. Have you ever been told by a medical professional not to take hormones?* If yes, please explain:	☐ Yes ☐ No
8. Do you smoke cigarettes? If yes, how many per day?*	☐ Yes ☐ No
9. Do you have a preferred method of birth control?	☐ Yes ☐ No
☐ Take a pill everyday ☐ A patch weekly ☐ Other (ring, injectable, IUD)	

2.Medical History	
1. Have you given birth within the past 6 weeks?*	☐ Yes ☐ No
2. Are you currently breast feeding?*	☐ Yes ☐ No
3. Do you have diabetes?*	☐ Yes ☐ No
4. Do you get migraine headaches? *	☐ Yes ☐ No
5. If yes, have you ever had the kind of headaches that start with warning signs or symptoms, such as: flashes of lights, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts?*	☐ Yes ☐ No
6. Do you have high blood pressure, hypertension, or high cholesterol? (please say yes even if it is controlled by medication)*	☐ Yes ☐ No
7. Do you or have you experienced any of the following (please mark all that apply)?* ☐ Heart attack ☐ Stroke ☐ Heart Disease ☐ Blood Clot	☐ Yes ☐ No
8. Have you ever been told by a medical professional that you are at risk of developing a blood clot?*	☐ Yes ☐ No
9. Are you planning any major surgery or planning surgery in the next 4 week?*	☐ Yes ☐ No
10. Have you had bariatric surgery or stomach reduction surgery?*	☐ Yes ☐ No
11. Do you have or have you ever had breast cancer?*	☐ Yes ☐ No
12. Do you or have you experienced any of the following conditions (please mark all that apply)?* ☐ Hepatitis ☐ Liver Disease ☐ Liver Cancer ☐ Gall bladder disease ☐ Jaundice (yellow skin or eyes)	☐ Yes ☐ No
13. Do you have any of the following (please mark all that apply)?* ☐ Cystic Fibrosis ☐ Multiple Sclerosis ☐ Lupus ☐ Rheumatoid arthritis ☐ Blood disorder	☐ Yes ☐ No
14. Do you take any medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? *If yes, please list them here:	☐ Yes ☐ No
15. Do you have any other medical problems?* If yes, please list them here:	☐ Yes ☐ No

3.Pregnancy Screen:	
1. 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 delivery?*	☐ Yes ☐ No
2. Have you had a baby in the past 4 weeks?*	☐ Yes ☐ No
3. Did you have a miscarriage or abortion in the last 7 days?*	☐ Yes ☐ No
4. Did your last menstrual period start in the last 7 days?*	☐ Yes ☐ No
5. Have you abstained from sexual intercourse since your last menstrual period or delivery?*	☐ Yes ☐ No
7. Have you been using a reliable contraceptive method consistently and correctly?* If yes, please explain:	☐ Yes ☐ No

5. Assessing Oral Hormonal Contraceptives *Please only fill out if you are unhappy with your current oral hormonal birth control.*	
1. Do you have acne and is it bothersome?	☐ Yes ☐ No
2. Do you have breakthrough bleeding?	☐ Yes ☐ No
3. If yes to 2, do you have breakthrough bleeding early in your cycle (days 1-9) or late in your cycle (days 10-21)?	☐ Early ☐ Late
4. Do you have absent or very light menstrual flow?	☐ Yes ☐ No
5. Do you have breast soreness during your cycle?	☐ Yes ☐ No
6. Do you have severe cramping?	☐ Yes ☐ No
7. Do you have nausea?	☐ Yes ☐ No
7. Do you have endometriosis?	☐ Yes ☐ No

**Questions required by the board of pharmacy*

Pharmacy:

Please list the name of the pharmacy where you fill your medications?_____

Do you plan to fill your hormonal birth control with Buena Vista Drug? (circle one) Yes / No

I have filled out this form to the best of my knowledge:

_____ / / _____

(Name, printed) (Date)

_____

(Name, signed)

Internal Use Only

*Pharmacist name:*_____ *Signature:*_____

*Notes:*_____

_____

_____

- ☐ DOB verified by valid photo ID
- ☐ Drug-Drug Interaction Run
- ☐ Weight (if patch is prescribed): _____
- ☐ BP Reading: (Left or Right Arm) Reading 1: ____/___mmHg Reading 2 (if needed): ___/___mmHg
- ☐ Referred Patient out: Yes / No Why?_____

_____

_____

Buena Vista Drug's Liability Form

Date:_____

Patient's Name:_____

Date of Birth:_____

Primary Care Physician (name and number): _____

I, _____, have read the Buena Vista Drug Self-Administer Hormonal Control Packet in full.

- I understand the signs and symptoms of when I need to contact a healthcare professional
- I understand that after 3 months if I am not satisfied with my birth control I will call the pharmacist for an appointment to discuss further options.
- I understand if I am not a candidate or the pharmacist recommends I need to see my primary care physician, it is my responsibility to make an appointment.
- I understand that my primary care physician will be faxed if a self-administered hormonal contraception is prescribed to me for unity of care.
- If I do not have a primary care doctor it is my responsibility to keep a copy of this visit from my records.
- I understand the pharmacy will operate under the facility's policies and procedures to ensure my privacy and confidentiality is maintained.
- I understand that all birth control methods are not 100% accurate and Buena Vista Drug is not responsible for any unintended pregnancy.
- I understand the risks of using birth control, including thromboembolic disorders such as blood clots, stroke, heart attack and others, and Buena Vista Drug is not responsible for any of these risks.
- I understand this appointment does not replace the importance of receiving recommended preventative health screenings.
- I understand this appointment does not replace the importance of receiving regular testing for sexually transmitted diseases.
- I understand that the pharmacist is practicing their Colorado State Board of Pharmacy Approved Statewide Protocol for Prescribing Hormonal Contraceptive Patches and Oral Contraceptives per 17.00.50 Evidence-Based Healthcare Service Pursuant to Statewide Protocol of Division and Appendix A of the Department of Regulatory Agencies: State Board of Pharmacy Rules per Colorado Board of Pharmacy.

I fully understand the medication being prescribed to me, I have asked all questions I had, and I am responsible to take the medication as it is prescribed by FDA.

_____ _____/_____/_____

(Name, printed) (Date)

_____

(Name, signed)

Buena Vista Drug

403 US Hwy 24 South Buena Vista, CO 81211

Phone: 719-395-2481 Fax: 719-395-2484

Date:_____

Patient's Name:_____

Date of Birth:_____

Primary Care Physician (name): _____

Primary Care Physician (number/ fax):_____

Your patient came to our pharmacy inquiring about self-administered hormonal contraception. The patient has completed the Buena Vista Drug Self-Administer Hormonal Contraception Consultation. The pharmacist practiced this under the Colorado State Board of Pharmacy Approved Statewide Protocol for Prescribing Hormonal Contraceptive Patches and Oral Contraceptives per 17.00.50 Evidence-Based Healthcare Service Pursuant to Statewide Protocol of Division and Appendix A of the Department of Regulatory Agencies: State Board of Pharmacy Rules per Colorado Board of Pharmacy.

In order to help promote uniformity of care, Buena Vista Drug has made the follow recommendation below for the patient. The medication was given to the patient by a prescription from a trained pharmacist. The patient has been fully counseled on: use, dosage, effectiveness, potential side effects, safety, importance of receiving recommended preventative health screenings, protection against sexually transmitted infections, and when to seek medical attention.

If you have any questions please feel free to contact us at any time.

Recommendation:

- ☐ Medication (see below)
- ☐ After consultation patient would like to make an appointment with you for more information on: ___ Copper IUD ___Progestin IUD ___ Implant
- ☐ Patient was not medically indicated for hormonal contraception and was recommended to be seen by your office.

Medication:

Refills:

_____ ___/___/___

Pharmacist (Date)

Buena Vista Drug's After Visit Summary

Date:_____ Patient's Name:_____ Date of Birth:_____

Based on the questionnaire, screening and consultation with the pharmacist, it is recommended:

- ☐ For you to take an oral hormonal birth control to be prescribed (see below)
- ☐ For you to use a hormonal birth control patch
- ☐ For you to make an appointment with primary care doctor to discuss:___ IUD ___ Implant
- ☐ You are not medically indicated for hormonal contraception; it is recommended to be seen by a doctor

*Medication Name:*_____ *Refills:*_____
*Please take:*_____

Do not forget:	Be seen right away if you have any of the ACHES:
• All medications have potential risks and side effects as discussed • This medication does not protect you against sexually transmitted infections • This appointment does not replace well woman health appointments or screenings with a primary care doctor	• A: abdominal pain • C: chest pain, shortness of breath, coughing up blood • H: headaches (severe) • E: eye problems such as blurred vision, flashing lights • S: severe leg pain with or without swelling

Thank you for completing the Buena Vista Drug's hormonal contraceptive program. If you have any questions about the medication or need to clarify something with us, please call us right away! We value you as our patient and thank you for visiting us today!

*Pharmacist Name:*_____ *Pharmacy Phone number:*_____