Pharmacist-Initiated Oral and Transdermal Self-Administered Combined Hormonal and Progestin-Only Contraceptives
Patient Questionnaire

Patient Name: _____ Birth Date(mm/dd/yy): _____ Age: _____ Visit Date(mm/dd/yy):_____

Part 1:

1. Insurance:	**2. Primary Care or Women's Health Provider:** **Practice Name:**	**3. Provider Phone #:**

4. Medication Allergies ***(List name of medication(s) and your reaction to them)***

_____

_____

5. Blood Pressure: **(Pharmacist Use Only)** **_____ mmHg (Reading 1)** **_____ mmHg (Reading 2)**
If initial BP ≥ 140/90 pharmacists may take second reading after patient has been seated for 5 or more minutes

6. Last Menstrual Period (mm/dd/yy):	**7. Height (feet/inches):**	**8. Weight (pounds):**	**9. BMI** **(Pharmacist Use Only)**
_____	_____	_____	_____

10. Are you currently taking a multi-vitamin or folic acid supplement? ☐ **Yes** ☐ **No**

11. Birth Control Method(s) You are Currently Using ***(Check all that apply)***:

☐None ☐Condoms ☐Patch ☐Ring ☐Pill ☐IUD ☐Implant ☐Depo Provera ☐Spermicide
☐Diaphragm ☐Withdrawal ☐Fertility Awareness/Natural Family Planning Other:_____

12. Birth Control Method(s) You Would Like to Discuss and Consider at This Visit:

☐Condoms ☐Patch ☐Ring ☐Pill ☐IUD ☐Implant ☐Depo Provera ☐Spermicide
☐Diaphragm ☐Withdrawal ☐Fertility Awareness/Natural Family Planning Other:_____

13. Birth Control History ***(List methods of birth control you've used in the past and any side effects or problems you've had with them)***

_____

_____

Part 2:

Screening to Be Reasonably Sure a Patient is Not Pregnant: ***It is reasonably certain a person is not pregnant if they have no signs or symptoms of pregnancy and answer yes to any questions 15-20.***	**Yes**	**No**
14. Do you think you might be pregnant? (Early signs and symptoms of pregnancy include a missed period, tender, swollen breast, nausea with or without vomiting, increased urination, and fatigue)	☐Yes	☐No
15. Did your last menstrual period start within the past 7 days?	☐Yes	☐No
16. Have you abstained from sex since your last menstrual period or delivery?	☐Yes	☐No
17. Have you used a reliable form of birth control consistently and correctly since your last period?	☐Yes	☐No

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18. Have you had a miscarriage or abortion in the last 7 days?	☐Yes	☐No
19. Have you given birth in the last 4 weeks?	☐Yes	☐No
20. Have you given birth within the last 6 months, are you fully or nearly fully breastfeeding, AND have you had no menstrual period since the delivery?	☐Yes	☐No

Part 3:

Medical History		
21. Have you ever been told by a medical professional NOT to take hormones?	☐Yes	☐No
22. Have you ever received an organ transplant?	☐Yes	☐No
23. Do you have lupus?	☐Yes	☐No
24. Do you have, or have you ever had breast cancer?	☐Yes	☐No
25. Have you had diabetes for more than 20 years? or have you had diabetes with kidney disease (nephropathy), disease of the back of your eye (retinopathy), or nerve damage (neuropathy)?	☐Yes	☐No
26. Have you ever had a heart attack or stroke or been told you had heart disease, including cardiomyopathy, heart failure, atrial fibrillation, and problems with your heart valves?	☐Yes	☐No
27. Do you have any other form of active cancer, including metastatic cancer, for which you are receiving therapy, or you are within 6 months of remission?	☐Yes	☐No
28. Do you have high blood pressure or hypertension? (Higher than 140/90)	☐Yes	☐No
29. Do you have, or have you ever had liver disease, hepatitis, liver cancer, or jaundice (yellowing of skin or eyes)?	☐Yes	☐No
30. Have you had liver disease with the flow of bile from your liver is blocked or reduced (cholestasis) related to birth control pills?	☐Yes	☐No
31. Do you have, or have you ever had gallbladder disease and still have your gall bladder?	☐Yes	☐No
32. Do you have ulcerative colitis or Crohn's disease?	☐Yes	☐No
33. Do you have, or have you ever had a blood clot in your leg (Deep Vein Thrombosis/DVT or Superficial Venous Thrombosis) or lung (Pulmonary Embolism/PE)?	☐Yes	☐No
34. Have you ever been told by a medical professional that you are at risk of developing a blood clot in your leg or lung?	☐Yes	☐No
35. Have you ever been told by a medical professional that you have a blood disorder that increases your risk of developing a blood clot?	☐Yes	☐No
36. Have you had recent major surgery or are you planning to have major surgery in the next 4 weeks after which you had to or will have to have a long period of time with limited or no movement?	☐Yes	☐No
37. Are you 35 years or older and do you smoke cigarettes or vape nicotine products?	☐Yes	☐No
38. Do you have multiple sclerosis with limited or no movement?	☐Yes	☐No
39. Do you have migraine headaches with aura (warning signs or symptoms such as flashes of light, blind spots, or tingling in your hands or face that comes and goes completely away before the headache starts)?	☐Yes	☐No
40. Do you have high cholesterol?	☐Yes	☐No

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41. Do you have 2 or more of the following conditions? **Check all that apply to you**:		
Age 35 or older	☐Yes	☐No
Smoke cigarettes or vape nicotine containing products	☐Yes	☐No
High LDL (bad cholesterol)	☐Yes	☐No
Low HDL (good cholesterol)	☐Yes	☐No
High triglycerides (fat in blood)	☐Yes	☐No
High blood pressure	☐Yes	☐No
Diabetes	☐Yes	☐No
42. Has it been less than 21 days since you have given birth or less than 30 days since you have given birth and you are breastfeeding?	☐Yes	☐No
43. Has it been less than 42 days since you have given birth?	☐Yes	☐No
Do you have **ANY** risk factors for blood clots? **See risk factors below, check all that apply to you:**		
Age 35 or older	☐Yes	☐No
Previous blood clot	☐Yes	☐No
Thrombophilia (blood disorder that makes you more likely to have blood clots)	☐Yes	☐No
Blood transfusion at delivery	☐Yes	☐No
Cardiomyopathy around time of giving birth	☐Yes	☐No
Major bleeding at time of giving birth	☐Yes	☐No
BMI > 30	☐Yes	☐No
Pre-eclampsia	☐Yes	☐No
Smoke cigarettes or vape nicotine containing products	☐Yes	☐No
Immobility (prolonged periods of limited or no movement)	☐Yes	☐No
44. Have you had Roux-en-Y, gastric bypass, or biliopancreatic surgery?	☐Yes	☐No

Part 4:

Medication History		
45. Are you taking any of the following medications?		
Fosamprenavir	☐Yes	☐No
Phenytoin	☐Yes	☐No
Carbamazepine	☐Yes	☐No
Phenobarbital	☐Yes	☐No
Topiramate	☐Yes	☐No
Oxcarbazepine	☐Yes	☐No
Primidone	☐Yes	☐No
Lamotrigine	☐Yes	☐No
Rifampin	☐Yes	☐No
Rifabutin	☐Yes	☐No
46. Do you take any other medications for **seizures**, **tuberculosis**, or **Human Immuno-deficiency Virus**?	☐Yes	☐No
If yes, list them here: _____		

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Part 5:

I am requesting that my pharmacist consult with me about my birth control options. I understand the following:

• The pharmacist is providing care based on the information I provide.

• The pharmacist will review my birth control options, if pharmacist is able to provide my selected birth control method, they will review with me how to use it, and what to expect.

• The pharmacist is available to answer all my questions about certain birth control options. I understand pharmacists and physicians have different education and training

• If the pharmacist is unable to provide my desired method of birth control, I will be referred to my primary care or women's health provider.

• Establishing a relationship with a primary care provider or women's health provider is important, so I should request information from the pharmacist about providers in my local area if I do not have one.

• It is advised to have regular visits with a primary care or women's health provider to receive recommended tests and screenings.

• 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 if used correctly and consistently.

• Hormonal birth control does not protect against sexually transmitted diseases (STDs). Condoms protect against STDs.

• I will contact my pharmacist and primary care provider or women's health provider regarding any side effects, problems, or changes to my health status or medications.

_____ _____

Patient Signature *Date*

_____ _____

Parent or Guardian Signature for Persons <18 Years of Age *Date*