BE WELL PRIMARY CARE LLC

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Hormonal Contraceptive Risk Assessment Questionnaire

Name: _____ Date of Birth: _____ Todays Date: _____

What was the date of your last Woman's Health Visit? _____ Last Menstrual Period: _____

Do you have a preferred method of birth control that you would like to use?

☐ A daily pill ☐ weekly patch ☐ A monthly vaginal ring ☐ Injectable (every 3 months) ☐ Other (IUD or implant)

Have you ever been pregnant? _____ Number of pregnancies? _____ Number of live births? _____

PREGNANCY SCREENING

Do you think you might be pregnant now?	☐ YES ☐ NO
Did you have baby less than 6 months ago? Delivery date? _____	☐ YES ☐ NO
Are you currently breastfeeding? If yes, describe (infant age, exclusively?): _____	☐ YES ☐ NO
Have you had a miscarriage or abortion in the last 7 days?	☐ YES ☐ NO
Have you abstained from sexual intercourse since your last menstrual period or delivery?	☐ YES ☐ NO
Have you been using a reliable contraception method consistently and correctly?	☐ YES ☐ NO
Have you ever experienced any irregular pattern, heavy, or prolonged vaginal bleeding?	☐ YES ☐ NO
Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection?	☐ YES ☐ NO
Has a pharmacist previously prescribed birth control for you? If yes, list month/year: _____	☐ YES ☐ NO
Did you ever experience a bad reaction to using hormonal birth control? If yes, please explain: _____	YES ☐ NO
Are you currently using birth control including pills, patch, ring, or injection?	☐ YES ☐ NO
Have you ever been told by a medical professional not to take hormones	☐ YES ☐ NO
Are you planning on becoming pregnant within the next year?	☐ YES ☐ NO

MEDICAL HISTORY

Do you have diabetes	☐ YES ☐ NO
Do you have migraine headaches? If yes, have you ever had the kind of headaches that starts with warning signs and symptoms, such as flashes of light, blind spots or loss of ability to see, stomach upset, tingling/numbness in your hands or face that comes and goes completely away before the headache starts, or it makes it hard to be in the light?	☐ YES ☐ NO
Are you being treated for inflammatory bowel disease?	☐ YES ☐ NO
Do you have high blood pressure, hypertension, or high cholesterol?	☐ YES ☐ NO
Have you had a heart attack, stroke, been diagnosed with ischemic heart disease or valvular heart disease?	☐ YES ☐ NO
Have you ever had a blood clot (DVT or PE)	☐ YES ☐ NO
Have you ever been told by a medical professional that you are at risk for developing blood clots	☐ YES ☐ NO
Have you had a recent major surgery or are you planning to have surgery in the next 4 weeks	☐ YES ☐ NO
Will you be immobile for a long period (flying or traveling)	☐ YES ☐ NO
Have you had bariatric surgery or stomach reduction surgery?	☐ YES ☐ NO
Do you have or have you ever had breast disease or breast cancer?	☐ YES ☐ NO
Have you had an organ transplant	☐ YES ☐ NO
Do you or have you had hepatitis, liver disease or cancer, gallbladder disease, or jaundice?	☐ YES ☐ NO
Do you have lupus, rheumatoid arthritis, or any blood disorders?	☐ YES ☐ NO
Do you take medication for seizures, tb, fungal infections, or HIV; if yes, please list: _____	☐ YES ☐ NO
Do you feel safe (at home/with your partner)	☐ YES ☐ NO