Tennessee Pharmacist-Provided Hormonal Contraceptives Self-Screening Questionnaire

Patient Name: _____ Date: _____
Patient Date of Birth: _____ Patient Weight: _____

1	Do you think you may be pregnant now?	Yes No
2	Have you given birth in the past 6 weeks?	Yes No
3	Have you had a miscarriage or abortion in the past 7 days?	Yes No
4	What was the first day of your last menstrual period?	___/___/___
5	Have you abstained from sex since the first day of your last menstrual period or delivery? (If yes, go to Question 7, if no, continue to Question 6)	Yes No
6	If currently sexually active, have you been using any form of contraceptive method?	Yes No
7	Do you smoke or use any tobacco products?	Yes No
8	Have you ever had a blood clot in your leg or your lung?	Yes No
9	Have you ever been told by a medical professional that you are at risk of developing a blood clot?	Yes No
10	Has any close relative (parent or sibling) ever had a blood clot in the leg or lung?	Yes No
11	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes No
12	Have you had bariatric surgery, lap band, or stomach reduction surgery?	Yes No
13	Do you get migraine headaches? If so, have you ever had these kinds of headaches that start with symptoms, such as flashes of light, blind spots, or tingling in your hand or face that come and then go completely away before the headache starts?	Yes No Yes No
14	Do you have any of the following medical conditions? (check all that apply) ____Diabetes ____Heart Disease ___Gall Bladder Disease ____High Blood Pressure ____Blood Clot ___Lupus ____High Cholesterol ____Hepatitis ___Rheumatoid Arthritis ____Heart Attack ____Liver Disease ___Blood Disorders ____Stroke ____Jaundice (yellow skin or eyes) ___Solid Organ Transplant ____Inflammatory Bowel Disease ____Cancer, if yes what type_____	
15	Is your mobility currently impaired or do you plan to have surgery that will temporarily or permanently impair your ability to walk?	Yes No
16	Do you have a family history of breast cancer?	Yes No
17	Do you take medications for any of the following conditions? (check all that apply, and if you mark yes please list the names of the medications) ___Seizures _____ ___Tuberculosis (TB) _____ ___Fungal Infections _____ ___Human Immunodeficiency Virus (HIV) _____	

18	Do you have any other medical problems or take any medications, including herbs or supplements? If yes, list them here:	Yes No
19	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection?	Yes No
20	Did you ever experience a bad reaction from using hormonal birth control? If yes, what kind of reaction occurred?_____	Yes No
21	Are you currently using any method of birth control, including pills, or a birth control patch, ring, or shot/injection? If yes, which one do you use? _____	Yes No
22	Have you ever been told by a medical professional not to take hormones?	Yes No
23	Are you currently breastfeeding?	Yes No
24	Do you have a preferred method of birth control that you would like to use? If yes, select your preferred method: ___A pill you take each day ___A patch that you change weekly ___A ring that you change monthly ___An injection that you receive every 12 weeks	Yes No

Do you have health insurance? Yes / No (if *yes*, please provide name of insurance: _____)
Do you have a women's health care provider? Yes / No (if yes, please provide name:_____)
When was your last women's health clinical visit? _____
Any allergies to medications? Yes / No (if *yes*, list them here:_____)
By signing below, you agree that that the information above has been filled out to the best of your knowledge.

Patient Signature: _____ Date: _____

Internal use only:
BP Reading _____/_____ Patient Referred (*circle if no medication provided*)
Reason for Referral (if referred): _____
Pharmacist Provider's Name:_____
Pharmacy Practice Phone:_____
Practice Address: _____
Collaborating Prescriber's Name: _____

Patient Name: _____
Patient Address: _____
Rx#_____
Medication prescribed: _____
Sig (Directions for Use):_____
Strength: _____ Dosage Form: _____Quantity: _____
Refills: _____ Substitution Allowed: Yes / No Quantity Dispensed: _____

Pharmacist's Signature: _____ Date: ___ / ___ / _____