HORMONAL BIRTH CONTROL SELF-SCREENING QUESTIONNAIRE

This self-screening questionnaire will help you assess potential risk factors for blood clots as you evaluate your hormonal birth control options. These options include all forms of hormonal birth control, including the birth control pill, patch and ring. Once completed, share this form with your healthcare provider or prescriber so you can make an informed decision about the type of birth control that meets your needs.

Your Name _____ Healthcare Provider _____ Date _____
Age_____ Date of Birth _____Weight _____ Date of last women's health clinical visit _____
Any allergies to medications? Yes/No If yes, please list them here: _____

Do you have a preferred method of birth control that you would like to use?
☐ Daily pill ☐ Weekly patch ☐ Vaginal ring ☐ Injectable (every 3 months) ☐ Other (intrauterine device, implant)

Background Information

1	What was the first date of your last menstrual period?	/ /	
2a	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection? (If no, go to question 3)	Yes ☐	No ☐
2b	Did you ever experience a bad reaction to using hormonal birth control?	Yes ☐	No ☐
2c	Are you currently using birth control pills, or a birth control patch, ring, or shot/injection?	Yes ☐	No ☐
3	Have you ever been told by a medical professional not to take hormones?	Yes ☐	No ☐
4	Do you smoke cigarettes?	Yes ☐	No ☐
5	Do you think you might be pregnant now?	Yes ☐	No ☐

Medical History

6	Have you given birth within the past 6 weeks?	Yes ☐	No ☐
7	Are you currently breastfeeding an infant who is less than 1 month of age?	Yes ☐	No ☐
8	Do you have diabetes?	Yes ☐	No ☐
9	Do you get migraine headaches, or headaches so bad that you feel sick to your stomach, you lose the ability to see, it makes it hard to be in light, or it involves numbness?	Yes ☐	No ☐
10	Do you have high blood pressure, hypertension, or high cholesterol?	Yes ☐	No ☐
11	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes ☐	No ☐
12	Have you ever had a blood clot in your leg or in your lung?	Yes ☐	No ☐
13	Have you ever been told by a medical professional that you are at a high risk of developing a blood clot in your leg or in your lung?	Yes ☐	No ☐
14	Have you had bariatric surgery or stomach reduction surgery?	Yes ☐	No ☐
15	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes ☐	No ☐
16	Do you have or have you ever had breast cancer?	Yes ☐	No ☐
17	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	Yes ☐	No ☐
18	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes ☐	No ☐
19a	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes ☐	No ☐
19b	If yes, list them here:		
20a	Do you have any other medical problems or take regular medication?	Yes ☐	No ☐
20b	If yes, list them here:		