

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, ring, and shot or injection. 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/Prescriber _____ Date _____
 Age _____ Date of Birth _____ Weight _____ Date of last women's health clinical visit _____
 Any allergies to medications? No Yes 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 <input type="checkbox"/>	No <input type="checkbox"/>
2b	Did you ever experience a bad reaction to using hormonal birth control?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Have you ever been told by a medical professional not to take hormones?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Do you smoke cigarettes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Do you think you might be pregnant now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Medical History

6	Have you given birth within the past 6 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7	Are you currently breastfeeding an infant who is less than 1 month of age?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	Do you have diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
10	Do you have high blood pressure, hypertension, or high cholesterol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12	Have you or a family member ever had a blood clot in your leg, your arm, or in your lung?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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, arm, or in your lung?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14	Have you had bariatric surgery or stomach reduction surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16	Do you have or have you ever had breast cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gallbladder disease, or do you have jaundice (yellow skin or eyes)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18	Do you have lupus, rheumatoid arthritis, or do you or any family member have a blood disorder (e.g., clotting or bleeding disorders)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19a	Do you take medication for seizures, tuberculosis (TB), fungal infections or human immunodeficiency virus (HIV)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19b	If yes, list them here:		
20a	Do you have any other medical problems or take regular medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20b	If yes, list them here:		

Adapted from California State Board of Pharmacy



DEDICATED TO HELPING REDUCE THE NUMBER OF LIVES LOST DUE TO PREVENTABLE BLOOD CLOTS