# HENDRICKS PHARMACY

THE CLAREMONT VILLAGE PHARMACY℠
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## Hormonal Contraception Self-Screening Tool Questions for Patient Completion

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Allergies: _____

Do you want your primary health care provider to receive a notice regarding this visit? Yes ☐ No ☐
If yes, primary health care provider's name: _____ Fax#_____
Do you have a preferred method of contraception that you would like to use? Yes ☐ No ☐ If yes, which one: _____

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|---|---|---|---|
| 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 ☐ |
| 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: | | |

Patient Signature: _____ Date: _____

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For Pharmacy Use

Blood Pressure: _____/_____ Pulse: ____ ☐ Eligible for pharmacist services. ☐ Refer patient to: _____

Product Selected: _____ QTY: 3 months

Sig: 1 tab QD / UD Start: Monday / _____

☐ Must use a back-up contraception method for 7 days.

Furnishing Pharmacist: _____ Date: _____

☐ Dr. Brian Garner, Pharm.D. NPI#1992055636 ☐ Dr. Christine Patel, Pharm.D. NPI#1376911784 ☐ Other: _____