California State Board of Pharmacy

HORMONAL CONTRACEPTION SELF-SCREENING TOOL QUESTIONS FOR PATIENT COMPLETION

Note to patient: print out and complete this questionnaire and bring to your pharmacy if you seek selfadministered hormonal contraception. You may wish to call your pharmacy first to make certain they are able to provide this service at this time. You may also obtain the form from participating pharmacies.

Patient Name:		Date:	
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Reviewing Pharmacist: ______ Date: ______

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	Yes 🗆	No 🗆
	shot/injection? (If no, go to question 3)		
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	Yes 🗆	No 🗆
	shot/injection?		
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	Yes 🗆	No 🗆
	stomach, you lose the ability to see, it makes it hard to be in light, or it involves		
	numbness?		
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	Yes 🗆	No 🗆
	disease?		
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	Yes 🗆	No 🗆
	developing a blood clot in your leg or in your lung?		
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	Yes 🗆	No 🗆
	weeks?		
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	Yes 🗆	No 🗆
	bladder disease, or do you have jaundice (yellow skin or eyes)?		
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	Yes 🗆	No 🗆
	immunodeficiency virus (HIV)?		
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:		