

# BIRTH CONTROL SCREENING FORM

Name:

Date of Birth:

\_\_\_\_/\_\_\_\_/\_\_\_\_

## Contact Information *(optional)*

Email:

Phone:

Primary Care Provider (PCP) Name:

Primary Care Provider (PCP) Phone Number:

Would you like us to send a summary of your visit to your primary care provider?  Yes  No  I don't have a provider

## Birth Control History *(optional)*

Are you currently using birth control?  Yes  No

If YES, list your current birth control:

What birth control methods would you like to discuss at this visit?

Pills  Patch  Ring  Shot  Other(s): \_\_\_\_\_

## Health History

Do you think you might be **pregnant** now?

Yes  No

Has a doctor ever told you **not to take birth control containing hormones**?

Yes  No

Have you **delivered a baby** in the past 6 weeks (42 days)?

Yes  No

Are you currently **breastfeeding**?

Yes  No

Do you **smoke cigarettes**?

Yes  No

Will you be **immobile** for a long period (e.g. planned leg surgery, long-distance travel with limited movement)?

Yes  No

Have you had **bariatric surgery (weight loss) surgery**, including stomach reduction?

Yes  No

Do you have (or have you ever had) the following **conditions**?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Breast cancer                | <input type="checkbox"/> Inflammatory bowel disease (IBD) - Crohn's or ulcerative colitis | <input type="checkbox"/> Superficial venous disorders (other than varicose veins) |
| <input type="checkbox"/> Chronic kidney disease (CKD) | <input type="checkbox"/> Heart disease or heart attack                                    | <input type="checkbox"/> Lupus  |
| <input type="checkbox"/> Liver disease or tumors      | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Blood disorders  |
| <input type="checkbox"/> Blood clot                   | <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Unexplained vaginal bleeding                             |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Sickle cell  | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Gall bladder disease         | <input type="checkbox"/> Solid organ transplant   | <input type="checkbox"/> None of the above  |
| <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Stroke   |   |
| <input type="checkbox"/> High blood pressure          |   |   |

Which of the following **medications** are you currently taking?

- |  |   |
|--|---|
| <input type="checkbox"/> Fosamprenavir         | <input type="checkbox"/> Phenytoin, carbamazepine, barbiturates (e.g.; phenobarbital, butalbital, secobarbital, amobarbital), primidone, topiramate, or oxcarbazepine |
| <input type="checkbox"/> Lamotrigine           | <input type="checkbox"/> None of the above  |
| <input type="checkbox"/> Rifampin or rifabutin |   |

Do you have any **medication allergies**?  Yes  No

If YES, list your medication allergies: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_