Hormonal Contraception Screening Guide & Risk Assessment Tool

Use this questionnaire when considering birth control options that contain the hormone estrogen, which may include the birth control pill, patch, or ring.
This questionnaire will help you and your healthcare provider determine if you are a good candidate for hormonal contraception.
Share the results of this questionnaire with your healthcare provider before taking hormonal birth control. Your healthcare provider will use your answers to the questions below to help you determine if you are a good candidate for hormonal contraception or if you should consider different birth control options that do not contain hormones.

Name _____ Healthcare Provider's Name _____ Date_____

Date of Birth _____ Age _____ Weight _____ What was the date of your last women's health clinical visit? _____

Any Allergies to Medications? Circle One: Yes / No If yes, list them here: _____

1	What was the first date of your last menstrual period? (month/day/year)	___ / ___ / ___	
2	Do you think you might be pregnant now?	Yes ☐	No ☐
3	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection? If no, go to question 4. If yes, please indicate date(s) here:	Yes ☐	No ☐
	A. Did you ever experience a bad reaction to using hormonal birth control?	Yes ☐	No ☐
	B. Are you currently using birth control pills, or a birth control patch, ring, or shot/injection?	Yes ☐	No ☐
4	Have you ever been told by a medical professional not to take hormones?	Yes ☐	No ☐
5	Do you smoke cigarettes?	Yes ☐	No ☐
6	Are you currently breastfeeding an infant who is less than 1 month of age?	Yes ☐	No ☐
7	Have you given birth within the past 6 weeks?	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 or any member of your family 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 ☐
19	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? If yes, list them here:	Yes ☐	No ☐
20	Do you have any other medical problems or take regular medication? If yes, list them here:	Yes ☐	No ☐

Adapted from the California Board of Pharmacy and California Code of Regulations, Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraception.
www.pharmacy.ca.gov/publications/hormonal_contraception_protocol_rphs.pdf