NEW YORK STATE DEPARTMENT OF HEALTH

CONTRACEPTION: Self-Screening Patient Intake Form

CONFIDENTIAL – PROTECTED HEALTH INFORMATION

Date (mm/dd/yyyy):	Date of Birth (mm/dd/yyyy):	Age:
Legal Name:	Name:	
Sex Assigned at Birth (circle one): Male / Female	Gender Identification (circle one): Male / Female / Other:	
Pronouns (circle one): She/Her/Hers, He/Him/His, They/Them/Their, Other:		
Street Address:		
City:	State:	ZIP Code:
Phone: ( )	E-mail Address:	

I have a Primary Care Provider: ☐ Yes ☐ No

Primary Care Provider: _____

Phone: ( ) _____

Fax: ( ) _____

Do you want information sent to your Primary Care Provider?
☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

Insurance Provider Name: _____

Ins ID # _____ Ins Group # _____

PCN # _____ Ins BIN# _____

Do you have any allergies to medications?
☐ Yes ☐ No
If yes, please list: _____

Do you have any allergies to food (ex. Soy, lactose)?
☐ Yes ☐ No
If yes, please list: _____

By signing at the end of this questionnaire, you are attesting that:

- The information is true and accurate to the best of your knowledge
- False responses could lead to unintended health consequences
- You are here voluntarily and you are not being coerced
- If you still have questions or concerns, you will consult with a primary care provider or reproductive health care provider
- I understand that the medication I am being dispensed is to be utilized to prevent pregnancy

Do you think you are pregnant or there is a chance you could be pregnant? ☐ Yes ☐ No

BACKGROUND INFORMATION

1. Have you previously had a contraceptive dispensed to you by a pharmacist? ☐ Yes ☐ No
   If yes, when was the last time a pharmacist dispensed a contraceptive to you? _____ / _____ / _____ (mm/dd/yyyy)
2. Other than a pharmacist, have you seen a provider (i.e. Physician, Nurse, Midwife etc.) concerning your reproductive and/or sexual health? ☐ Yes ☐ No
   If yes, when was the date of your last visit? _____ / _____ / _____ (mm/dd/yyyy)

CONTRACEPTION HISTORY

3. Has a health care provider ever advised you that you should not take hormones or hormonal contraception? ☐ Yes ☐ No
   If yes, what was the reason? _____
4. Have you ever used any form of hormonal contraception including but not limited to birth control tablets, the patch, vaginal ring, or birth control shot/injection? ☐ Yes ☐ No
5. Did you ever experience a bad reaction to using hormonal contraception? ☐ Yes ☐ No
   If yes, what kind of reaction occurred? _____
6. Are you currently using any method of birth control including pills, patch, ring or shot/injection? ☐ Yes ☐ No
   If yes, which one do you use? _____
7. Do you have a preferred method of birth control that you would like to use? ☐ Yes ☐ No
   If yes, please check one: ☐ Oral pill ☐ Skin patch ☐ Vaginal ring ☐ Injection ☐ Other (IUD, implant)

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MEDICAL SCREENING QUESTIONS

8. Did you have a baby less than 6 months ago, are nearly all your infant's meals are breast/chest feedings, AND have you had no menstrual period since the delivery? ☐ Yes ☐ No
9. Have you had a baby in the last 6 weeks? ☐ Yes ☐ No
10. Did you have a miscarriage or abortion in the last 7 days? ☐ Yes ☐ No
11. Did your last menstrual period start within the past 7 days? ☐ Yes ☐ No
12. Have you abstained from sexual intercourse since your last menstrual period or delivery? ☐ Yes ☐ No
13. Have you been using a reliable contraceptive method consistently and correctly? ☐ Yes ☐ No
14. What was the first day of your last menstrual period? _____ / _____ / _____ (mm/dd/yyyy)
15. Have you had a recent change in vaginal bleeding that worries you? ☐ Yes ☐ No
16. Have you given birth within the past 21 days? ☐ Yes ☐ No
    If yes, how long ago? _____
17. Are you currently breastfeeding? ☐ Yes ☐ No
18. Do you use tobacco products? ☐ Yes ☐ No
19. Do you have diabetes? ☐ Yes ☐ No
20. Do you get migraine headaches? ☐ Yes ☐ No
    If yes, have you ever had the kind of headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts? ☐ Yes ☐ No ☐ N/A
21. Are you being treated for inflammatory bowel disease? ☐ Yes ☐ No
22. Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication) ☐ Yes ☐ No
23. Have you ever had a heart attack or stroke, or been told you had any heart disease? ☐ Yes ☐ No
24. Have you ever had a blood clot? ☐ Yes ☐ No
25. Have you ever been told by a healthcare professional that you are at risk of developing a blood clot? ☐ Yes ☐ No
26. Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? ☐ Yes ☐ No
27. Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc.) ☐ Yes ☐ No
28. Have you had bariatric surgery or stomach reduction surgery? ☐ Yes ☐ No
29. Do you have or have you ever had breast cancer? ☐ Yes ☐ No
30. Have you had an organ transplant? ☐ Yes ☐ No
31. 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
32. Do you have lupus, rheumatoid arthritis, or any blood disorders? ☐ Yes ☐ No
33. Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)? ☐ Yes ☐ No
    If yes, list them here: _____
34. Do you have any other medical problems or take any medications, including herbs or supplements? ☐ Yes ☐ No
    If yes, list them here: _____
    _____

Patient Signature: _____ Date: _____ / _____ / _____ (mm/dd/yyyy)

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CONFIDENTIAL – PROTECTED HEALTH INFORMATION

1. Blood Pressure Reading: _____ / _____ mmHg

2. Height: _____
   Weight: _____
   BMI: _____
   (Review for Patch: BMI<30 AND weight <200lbs/<90kg)

3. If contraception was dispensed, please complete the following:
   Drug: _____
   Directions: _____
   Quantity: _____
   Dispense up to 12 months of medication pursuant to patient preference and insurance limitations.

4. Healthcare Provider (if known and patient has not opted out) contacted/notified of therapy:
   ☐ Yes, Date (mm/dd/yyyy): _____ / _____ / _____ ☐ No

5. If contraception was not dispensed/administered, please indicate reason(s) for referral: _____
_____
_____
_____
_____

Pharmacist Signature: _____ Date (mm/dd/yyyy): _____ / _____ / _____