West Virginia Pharmacy Accessible Birth Control (Pharmacy ABC) Self-Screening Questionnaire

Name _____ Health Care Provider's Name _____ Date _____
Date of Birth _____ Age _____ (must be 18) Weight ____ Ht _____Do you have health insurance? Yes/No
What was the date of your last women's health clinical visit? _____
Healthcare Center _____
Any allergies to Medications? Yes/No If yes, list them here _____
Current method of birth control _____ Types of birth control ever used _____

What is your preferred method of birth control? STOP AND SEE PHARMACIST AFTER ANSWERING THIS QUESTION

☐ A daily tablet ☐ A weekly patch ☐ A monthly vaginal ring ☐ Injectable (every 3 months) ☐ Other (IUD, implant)

Background Information:

1	Do you think you might be pregnant now?	Yes ☐ No ☐
2	What was the first day of your last menstrual period?	___/___/___
3	Have you ever been told by a medical professional not to take hormones?	Yes ☐ No ☐
4	Have you ever taken birth control pills, or used a birth control patch, ring, or injection?	Yes ☐ No ☐
	Have you previously received birth control prescribed to you by the pharmacist?	Yes ☐ No ☐
5	Did you ever experience a bad reaction to using hormonal birth control?	Yes ☐ No ☐
	- If yes, what kind of reaction occurred?	
6	Are you currently using any method of birth control including pills, or a birth control patch, ring, or injection?	Yes ☐ No ☐
	- If yes, which one do you use?	
7	Do you smoke cigarettes?	Yes ☐ No ☐

Medical History:

8	Have you had a recent change in vaginal bleeding that worries you?	Yes ☐ No ☐
9	Have you given birth within the past 21 days? If yes, how long ago? _____	Yes ☐ No ☐
10	Are you currently breastfeeding?	Yes ☐ No ☐
11	Do you have diabetes?	Yes ☐ No ☐
12	Have you ever had a migraine headache? If so, 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 ☐
13	Are you being treated for inflammatory bowel disease?	Yes ☐ No ☐
14	Do you have high blood pressure or high cholesterol? (Please indicate yes, even if it is being controlled by medication).	Yes ☐ No ☐
15	Have you ever had a heart attack or stroke or been told you have any heart disease?	Yes ☐ No ☐
16	Have you ever had a blood clot?	Yes ☐ No ☐
17	Have you ever been told by a medical professional you are at risk of developing a blood clot?	Yes ☐ No ☐
18	Have you had recent major surgery or are you planning to have surgery?	Yes ☐ No ☐
19	Will you be immobile for a long period? (e.g. flying on a long airplane trip, etc)	Yes ☐ No ☐
20	Have you had bariatric surgery or stomach reduction surgery?	Yes ☐ No ☐
21	Do you have or have you ever had breast cancer?	Yes ☐ No ☐
22	Have you had a solid organ transplant?	Yes ☐ No ☐
23	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 ☐
24	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes ☐ No ☐
25	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes ☐ No ☐
	- If yes, list them here:	
26	Do you have any other medical problems or take any medications, including herbs or supplements?	Yes ☐ No ☐

	- If yes, list them here:	
27	Have you had any of the following vaccinations? If yes, when?	Yes ☐ No ☐
	HPV _____ Tdap/Td _____ Hep A _____ Hep B _____	
	Flu _____ Meningitis _____ Pneumococcal _____	

Pregnancy Screen:

a.	Did you have a baby less than 6 months ago, are you fully or nearly-fully breast feeding, AND have you had no menstrual period since the delivery?	Yes ☐ No ☐
b.	Have you had a baby in the last 4 weeks?	Yes ☐ No ☐
c.	Did you have a miscarriage or abortion in the last 7 days?	Yes ☐ No ☐
d.	Did your last menstrual period start within the past 7 days?	Yes ☐ No ☐
e.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes ☐ No ☐
f.	Have you been using a reliable contraceptive method consistently and correctly?	Yes ☐ No ☐

Signature _____ Date _____

☐ Verified DOB with valid photo ID ☐ BP Reading _____/_____ * Must be taken by RPh

Note: RPh must refer patient if either systolic or diastolic reading is out of range, per algorithm

Drug Prescribed _____

Directions_____

Pharmacist Name _____ RPh Signature_____

Pharmacy Address _____ Pharmacy Phone _____

-AND/OR-

☐ Patient referred

Notes: _____

_____

_____

☐ Medical Referral for 1) LARC 2) Further Medical Evaluation 3) Annual reproductive health visit

_____

☐ Tobacco Cessation: _____

☐ Immunizations: _____