MARYLAND SELF-SCREENING RISK ASSESSMENT FOR BIRTH CONTROL

THIS FORM SHOULD BE FILLED OUT BY THE PATIENT

Patient Name_____ Date_____/_____/_____
Patient Address_____ Date of Birth ___/___/____
Name of your Primary Care Provider (PCP) or Reproductive Health Care Provider
_____ Address_____
When did you last visit a PCP or Reproductive Health Care Provider: Date _____/_____/_____

Please answer the following questions about your medical history:

PREGNANCY SCREEN			
1	Do you think you might be pregnant now? If you answered **YES**, please **STOP** here.	Yes ☐	No ☐
2	Did you have a baby in the past 4 weeks?	Yes ☐	No ☐
3a	Did you have a baby less than 6 months ago?	Yes ☐	No ☐
3b	Are you fully or nearly-fully breast feeding?	Yes ☐	No ☐
3c	Have you had a menstrual period since the delivery?	Yes ☐	No ☐
4	Did your last menstrual period start within the last 7 days?	Yes ☐	No ☐
5	Have you been using a reliable birth control method consistently and correctly?	Yes ☐	No ☐
6	Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes ☐	No ☐
MEDICAL HISTORY			
7	Did you have a baby in the past 21 days?	Yes ☐	No ☐
8	Did you have a baby in the past 6 weeks?	Yes ☐	No ☐
9	Have you ever had surgery? If so, list the date of your most recent procedure?	___/___/___	
10	Have you ever had a blood clot in the arms, legs, lungs or other parts of the body?	Yes ☐	No ☐
11	Have you ever been told by your PCP that you are at risk of having a blood clot?	Yes ☐	No ☐
12	Do you have high blood pressure?	Yes ☐	No ☐
13a	Do you have diabetes? If you answered **NO**, skip to question 14.	Yes ☐	No ☐
13b	Have you had diabetes for more than 20 years?	Yes ☐	No ☐
13c	Are you using insulin?	Yes ☐	No ☐
13d	Do you have damage to your eyes, nerves of the feet, hands, kidneys or any other organ from diabetes?	Yes ☐	No ☐
14	Do you have high cholesterol?	Yes ☐	No ☐
15	Have you ever had a heart attack or stroke, or been told you had heart disease?	Yes ☐	No ☐
16a	Do you use any form of tobacco, e.g. vape e-cigarette, e-hookah, or e-liquid; chew tobacco, dip snuff, or smoke cigarettes? If you answered **NO**, skip to question 17.	Yes ☐	No ☐
16b	If you answered **YES**, how often do you use any form of tobacco?	_____	
16c	How much tobacco do you use in a day?	_____	
17	Do you ever have headaches that start with flashes of light, blind spots, or tingling in your hands or face, that comes and goes away before the headache starts?	Yes ☐	No ☐

PLEASE TURN OVER

18	Have you had a recent change in vaginal bleeding that worries you?	Yes ☐	No ☐
19	Have you had stomach reduction or weight loss surgery?	Yes ☐	No ☐
20	Do you have, or have you ever had breast cancer?	Yes ☐	No ☐
21	Have you had a heart, liver, kidney, lung, or other organ transplant?	Yes ☐	No ☐
22	Do you have lupus?	Yes ☐	No ☐
23	Have you ever had hepatitis, liver disease, liver cancer, gall bladder disease, or jaundice (yellow skin/eyes)?	Yes ☐	No ☐
24	Do you have or have you ever had any other medical conditions that we have not discussed? Please list them here:_____	Yes ☐	No ☐
MEDICATION HISTORY			
25	Do you take any medications or supplements? Please list them here: _____ _____	Yes ☐	No ☐
26	Have you had any allergies or bad reactions to any medication you have taken? Please list them here: _____	Yes ☐	No ☐
27	Have you ever been told by a health care provider not to take birth control pills, patch, vaginal ring, injection, implant, diaphragm, intrauterine device (IUD) or coil or any other? _____	Yes ☐	No ☐
28	Have you ever used birth control in the past? If **YES**, circle the type you have used: birth control pills, patch, vaginal ring, injection, implant, diaphragm, IUD or coil, or any other? _____	Yes ☐	No ☐
29	When did you last use birth control pills, patch, vaginal ring, injection, implant, diaphragm, IUD or coil, or any other?	___/____/___	
30	Is there a type of birth control that you would like to use? If **YES**, circle your response: birth control pills, patch, vaginal ring, injection, implant, diaphragm, IUD or coil, or any other? _____	Yes ☐	No ☐
31	Have you taken emergency contraception in the last 5 days?	Yes ☐	No ☐

Pharmacist Internal Use Only

Blood Pressure Reading_____mmHg Pulse_____b/min Weight_____lbs
Pharmacist Name_____
Phone _____
Pharmacy Name_____Address_____
Notes _____
_____