Patient Questionnaire for Oral Contraceptives / Hormonal Therapy

Your name: ___________________________________ Today's date: ________________

Your age today: ___________ Who is here with you today? ____________________

Please tell us why you are interested in discussing this type of medication. (Check all that apply.)

__ painful periods __ infrequent periods

__ heavy or prolonged bleeding __ frequent bleeding or bleeding between periods

__ contraception __ acne

__ moodiness around periods / PMS __ other: ____________________

YOUR MEDICAL HISTORY: Do you have, or have you EVER had, any of the following?

YES NO High blood pressure

YES NO Diabetes, high blood sugar levels, or high insulin levels

YES NO Blood clot (in the legs, lungs, etc)

YES NO Chest pain

YES NO Heart problems

YES NO Liver problems

YES NO Kidney problems

YES NO Tumors

YES NO Polycystic ovarian syndrome

YES NO Unexplained vaginal bleeding or discharge

YES NO Headaches
YES  NO  If you answered YES to headaches, have you ever had sensations prior to headaches like numbness, tingling, weakness, visual changes (like blurry vision or flashing lights), or anything that indicates to you that the headache is coming? (This is called an “aura.”)

Please list any other medical conditions or surgeries that you have EVER had in your life:

Please list all medications that you are taking, both daily and “as needed,” along with their doses. Please include over-the-counter and herbal medicines:

Age of your first period: __________  First day of last menstrual period (date): __________

NAME____________________  DATE____________________

How often do you start a new period?
___ Every 2-3 weeks  ___ Every 4-6 weeks
___ Every 6 weeks or more  ___ Not sure

If your periods are irregular, what is the longest you have ever gone without a period? ______

Average number of days that your period lasts: _____

On your heaviest days, how many pads or tampons are soaked, on average, in 24 hours? ______

**FAMILY HISTORY**

Has anyone in your family had any of the following conditions? If yes, please explain.

YES  NO  blood clots (legs, lungs, brain, etc)

YES  NO  genetic clotting disorders like Factor V Leiden, protein C, protein S deficiency, etc.

(even if they have never had a clot)
YES NO  lupus (SLE) or other autoimmune diseases
YES NO  recurrent miscarriages (3 or more)
YES NO  heart attack before age 55
YES NO  stroke before age 55
YES NO  high cholesterol before age 55
YES NO  cancer of the breast, ovary, uterus, or cervix
YES NO  other significant medical problems

List any other questions or concerns that you have today:

Your signature: ______________________  Date: __________

Your family member’s signature if they are helping you fill out this form:_____________________

DOCTOR’S NOTES ONLY:

Doctor’s signature: ______________________________  Version 4/2014