WEST SIDE PEDIATRICS

Patient Questionnaire for Oral Contraceptives / Hormonal Therapy

Patient Name: _____ DOB: _____ 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 and "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 a daily and "as needed," along with their doses. Please include all over the counter and herbal medicines:

_____

_____

Patient Name: _____ Date: _____

Age at time of your first period: _____ Date of your last menstrual period: _____

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 disease
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: _____ Date: _____