UNIVERSITY OF TORONTO SCARBOROUGH

HEALTH & WELLNESS CENTRE

Hormonal Contraceptive Screening Questionnaire

Please answer the following questions to the best of your knowledge. This will help the nurse and doctor in determining the best form of contraception for you. If possible, before your appointment with a nurse, please email the completed form to health.utsc@utoronto.ca.

What is the reason you are requesting a prescription for hormonal birth control?

☐ birth control ☐ acne treatment ☐ cycle control ☐ other

Have you ever been sexually active?

☐ no ☐ yes If yes, for how long? _____

Have you ever had a Pap test?

☐ no ☐ yes Date: _____ Results: _____

What do you currently do to prevent pregnancy? Describe: _____

Have you previously used hormonal contraception?

☐ no ☐ yes If yes, which one? _____ When did you last use this method? _____

Do you have any allergies?

☐ no ☐ yes If yes, please list: _____

Are you taking any medications or herbal remedies?

☐ no ☐ yes If yes, please list: _____

Do you use any tobacco?

☐ no ☐ yes Marijuana: ☐ no ☐ yes If yes, amount _____ ☐ per day ***or*** ☐ per week

Do you/have you ever had any mental health concerns or diagnosis?

☐ no ☐ yes If yes, describe: _____

When was the first day of your last menstrual period? _____

Have you, your parents, grandparents or siblings ever had any of the following?

Blood clots in the legs/lungs/eyes or elsewhere:

☐ no ☐ yes If yes, describe: _____

Stroke:

☐ no ☐ yes If yes, describe: _____ At what age did this occur? _____

Heart attack or coronary disease:

☐ no ☐ yes If yes, describe: _____

Cancer of the breast or reproductive (sex) organs:

☐ no ☐ yes If yes, describe: _____

Unusual vaginal bleeding:

☐ no ☐ yes If yes, describe: _____

Liver disease, jaundice or tumours:

☐ no ☐ yes If yes, describe: _____

Partial or complete loss of vision caused by disease:

☐ no ☐ yes If yes, describe: _____

Migraine headaches (with or without auras):

☐ no ☐ yes If yes, describe: _____

Diabetes:

☐ no ☐ yes If yes, age when diagnosed: _____ ☐ Type 1 ☐ Type 2

High blood pressure:

☐ no ☐ yes If yes, describe: _____

Uterine fibroids:

☐ no ☐ yes If yes, describe: _____

Do you know which hormonal contraceptive method you'd like to start?

☐ The pill ☐ The patch ☐ The ring ☐ IUS (hormonal) ☐ IUD (copper) ☐ Unsure