

**SECTION 2.1
ORAL CONTRACEPTIVE USE**

I. Client Selection

- A. Indications – combined oral contraceptive pills (COCs) may be provided:
1. When contraindications do not exist;
 2. Post-pregnancy:
 - a. May begin immediately after a first or second trimester abortion;
 - b. May initiate 3-4 weeks after delivery if non-lactating and no risks for venous thromboembolism (VTE);
 - c. Exercise caution in nursing women less than six months postpartum. Document discussion of potential risks/benefits such as decrease in milk supply.
- B. Contraindications – refrain from providing. Conditions that represent an unacceptable health risk if the contraceptive method is used. (based on Centers for Disease Control and Prevention (CDC) U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (USMEC) MMWR Early Release 2010; 59 May 28, 2010)
1. History of deep vein thrombosis or pulmonary embolism; known thrombogenic mutations such as Protein C or S deficiencies, Factor V Leiden, and antithrombin deficiencies (USMEC 2010), or EXTENSIVE familial history of deep vein thrombosis or family history of unexplained venous thromboembolism at a young age. (Thrombosis related to either a known trauma or an IV needle is not necessarily a reason to avoid use of COCs.);
 2. History of systemic lupus erythematosus (SLE) with positive (or unknown) antiphospholipid antibodies;
 3. History of cerebrovascular accident (stroke);
 4. Vascular, coronary artery, ischemic heart disease, myocardial infarction or current angina pectoris, or history thereof; complicated valvular heart disease, such as pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis; history of peripartum cardiomyopathy;
 5. Age ≥ 35 and smoking ≥ 15 cigarettes a day;
 6. Hypertension: systolic ≥ 160 or diastolic ≥ 100 ;
 7. Diabetes mellitus with clinically manifested vascular disease (diabetic nephropathy, retinopathy, neuropathy or peripheral vascular disease); diabetes of > 20 years duration;
 8. Known or suspected carcinoma of the breast or endometrium, or other estrogen-dependent neoplasia. COC use may be considered, in consultation with the physician, for women with a past history of breast cancer but no evidence of estrogen dependence in the cancer and no recurrence for 5 years;
 9. Hepatocellular adenoma, liver cancer, or history thereof; active viral hepatitis, severe cirrhosis or markedly impaired liver function currently;
 10. Migraine headaches with focal neurological symptoms (aura, visual changes, scotoma, flashing lights, dysphasia, numbness of face/extremities); development of migraine headaches without aura while on estrogen containing contraceptives and age ≥ 35 years;

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11. Solid organ transplant with complicated: graft failure, rejection, cardiac allograft vasculopathy;
 12. Unexplained abnormal vaginal or uterine bleeding, NOT including irregular menses;
 13. Planned major surgery with prolonged immobilization or any surgery on the legs;
 14. Suspected pregnancy;
 15. Less than 21 days postpartum;
 16. Postpartum between 21 - 42 days if clients has other risk factors for VTE such as age \geq 35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30, postpartum hemorrhage, post cesarean delivery, pre-eclampsia, or smoking; plus other risk factors such as smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy. (Update to CDC USMEC MMWR Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period; 60 July 8, 2011).
- C. Special conditions requiring further evaluation: The theoretical/proven risks usually outweigh the advantages of using the method (Category 3). The client must be provided with information regarding the way in which these conditions may add to a health risk for her. This discussion must be documented. (Based on USMEC 2010)
1. Adverse cardiovascular risk profile (see V. Management of Women with Special Conditions Requiring Further Evaluation of this Section);
 2. Active or medically treated gallbladder disease, history of COC-related cholestasis;
 3. Migraine headaches without focal neurological symptoms (aura, visual changes, scotoma, flashing lights, dysphasia, numbness of face/extremities) and \geq 35 years old. (See V. Management of Women with Special Conditions Requiring Further Evaluation of this Section);
 4. Elevated blood pressure measurements – 140-159/90-99 on three separate visits within a two week period. (See Flow Chart for Management of Clients Using Combined Oral Contraceptives Who Develop High Blood Pressure, Page 6 of this Section);
 5. Age \geq 35 years old and smoking < 15 cigarettes per day;
 6. Seizure disorder, currently taking anticonvulsants that affect liver enzymes (see V. Management of Women with Special Conditions Requiring Further Evaluation of this Section);
 7. History of bariatric surgery, malabsorptive procedures, decreased absorption of nutrients and calories by shortening the functional length of the small intestines (Roux-en Y gastric bypass, biliopancreatic diversion);
 8. History of inflammatory bowel disease (IBD) (ulcerative colitis, Crohn disease) and at increased risk for VTE (e.g. those with active or extensive disease, surgery, immobilization, corticosteroid use, vitamin deficiency, or fluid depletion). For women with mild IBD and no other risk factor for VTE, the benefits of an estrogen containing method generally outweigh the risks. (USMEC 2010)

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9. Postpartum between 21 - 42 days if clients has other risk factors for VTE such as age \geq 35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI \geq 30, postpartum hemorrhage, post cesarean delivery, pre-eclampsia, or smoking. (Update to CDC USMEC MMWR Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period; 60 July 8, 2011);
10. 21 to 30 days postpartum and breastfeeding.

II. Client Education/Informed Consent – must include:

- A. All clients choosing to use oral contraceptives must receive the following information:
 1. Fact sheet on all contraceptive options available if she is a new client or is undecided as to what method she wishes to use;
 2. A copy of the FDA approved detailed client labeling pamphlet. The importance of reading the FDA pamphlet must be explained to the client;
 3. Instructions on how to take the pill. (For instructions, see Contraceptive Technology, 19th Edition, pp. 249-257);
 4. Information that the effectiveness of COCs and progestin only pills (POPs) may be decreased by some medications (See Drug Interactions V.F of this Section);
 5. The importance of scheduled follow-up visits (See Follow Up, VIII, of this Section);
 6. Importance of informing their other providers of their use of oral contraceptives;
 7. Information regarding discontinuation of oral contraceptives, and the recommendation that she complete the cycle of pills she is taking. If she does not wish to get pregnant, she should start using another method before the day she was due to start her next cycle of pills;
 8. Information regarding sexually transmitted infections (STIs), including counseling that oral contraceptives provide no protection. Use of either male or female condoms should be recommended for clients in need of protection from STIs.
- B. All clients choosing to use oral contraceptives must sign the following:
 1. General family planning program consent.
 2. Hormonal contraceptive consent for the provision of oral contraceptives. (Does not need to be re-initialed yearly unless there is a change in health status).

III. Medical Screening and Evaluation

- A. History – as per Title X Guidelines (See Section 1.4 - Health Care Services of the Nursing Manual)
- B. Examination – as per Title X Guidelines (See Section 1.4 - Health Care Services of the Nursing Manual)
- C. Laboratory – tests per Title X Guidelines (See Section 1.4 - Health Care Services of the Nursing Manual)
- D. Provision of oral contraceptives through Delayed Exam (See Section 2.10 - Delayed

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Exam of the Nursing Manual)

IV. Provision of Oral Contraceptive Pills (OCPs)

CURRENT METHOD	START OCP	BACK UP
No effective contraception in preceding cycle	On or prior to day 5 of cycle, OR take first pill during this office visit if pregnancy can be ruled out (Quick Start), OR take first pill the day after taking emergency contraceptive pills (ECPs) (Jump Start)	Back up method recommended for 7 days
NuvaRing® or Ortho Evra® in preceding cycle	Anytime within 7 days of the last NuvaRing or Ortho Evra patch being removed (no later than when a new cycle of NuvaRing or Ortho Evra would have been started) or start OCPs immediately if the client has been using her method correctly and consistently, or it is reasonably certain she is not pregnant.	None
Progestin-only pills (POPs) in preceding cycle	Any day of the month. There should be no skipped days between last POP pill and first combined oral contraceptive	Back up method recommended for 7 days
Implanon® implant in preceding cycle	On the same day the implant is removed	None
DMPA in preceding cycle	On or before the day when the next injection is due	None
ParaGard® or Mirena® in place	On the same day that the IUD is removed. Consider starting a hormonal method before the IUD is removed.	Back up method recommended for 7 days
After first or second (≤ 24 weeks gestation) trimester loss or termination	Immediately or within 5 days of loss or termination	None
Postpartum	Combined oral contraceptives: at 21 days postpartum in women who elect not to breastfeed and have no risk factors for VTE (Category 2); 30 – 42 days postpartum if no risk factors for VTE in lactating women (Category 2). Progestin only pills: May start if client is less than 21 days postpartum. Category 1 if not breastfeeding; category 2 if breastfeeding.	Back up method should be considered for 7 days
Any other contraceptive method	On first day of cycle On days 2-5 of cycle	No back up method is needed Back up method should be used for 7 days

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V. Management of Women With Special Considerations Requiring Further Evaluation

- A. Adverse Cardiovascular Risk Profile
- B. If a woman has two or more risk factors, the case must be evaluated by, and use of oral contraceptives approved by a physician:
 - 1. Age \geq 35;
 - 2. Smoking cigarettes;
 - 3. High cholesterol levels;
 - 4. Diabetes;
 - 5. Chronic hypertension.
- C. Diabetes mellitus
 - 1. Oral contraceptive use in women with diabetes must be individualized. As risk factors increase in number or severity, it may become less appropriate to prescribe oral contraceptives
 - 2. Consider involving the primary care provider managing the client's diabetes if she is initiated on oral contraceptives.
- D. High Blood Pressure
 - 1. If hypertension is controlled with diet or medication, the complete cardiovascular risk profile (B.1 – 5 above) must be considered.
 - 2. Combined Oral contraceptives may induce hypertension in a very small percentage of previously normotensive women. If a COC user is found to have a significant rise in blood pressure to 140 systolic or above/ 90 diastolic or above, the rise could be due to the use of the COC.
 - 3. Management - Please refer to the flow chart on the next page for management of hypertension that occurs in women using COCs.

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Flow Chart for the Management of Clients Using Combined Oral Contraceptives (COCs) Who Develop High Blood Pressure

SYSTOLIC 140 or above
And/or
DIASTOLIC 90 or above



Have client return two or more times within two weeks in a resting state for re-evaluation.

If any two or more readings on at least two different visits are ≥ 140 systolic or ≥ 90 diastolic, consider the following options:

- +Physician consultation
- +Refer for medical evaluation
- +Switch to another method (progestin-only is OK)

Diastolic of ≥ 100 on any one occasion - stop COCs immediately. Initiate interim method of contraception; client must be referred for a medical evaluation.

Continuation of COCs requires documentation of physician approval and a plan for follow-up.



If COCs are discontinued, re-check BP within three months.

- If still ≥ 140 systolic or ≥ 90 diastolic, refer for evaluation.
- If < 140 systolic or < 90 diastolic, may then try a very low dose (20 ug estrogen) combination pill or progestin-only method.

If very low dose (20 ug estrogen) combination pill or progestin only method is initiated:

- Monitor BP monthly for three months. If BP rises to ≥ 140 systolic or ≥ 90 diastolic at any time, discontinue estrogen-containing hormonal contraceptives.
- Offer alternative method.
- Recheck BP within 3 months. See first bullet in this box.

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D. Headaches

1. Management of headaches that start or worsen after the initiation of COCs is up to the discretion of the practitioner and client and may include any of the following:
 - a. Referral for headache evaluation;
 - b. Change in pill prescription including very low dose COCs (20 ug) or progestin only methods;
 - c. Change in birth control method;
 - d. For headaches during the hormone free interval, instruct the client to skip the week of placebo pills and immediately start a new pack of COCs (see extended use regimen, VI. B, of this Section).
2. Common Migraine Headaches (without focal neurologic symptoms [aura, visual changes, scotoma, flashing lights, dysphasia, numbness of face/extremities])
 - a. A trial of COCs may be provided for women with a history of migraine headaches without focal neurological symptoms. The client must be advised to report any increase in the frequency and severity of such headaches. The initiation of an estrogen containing method to women \geq 35 years old with a history of migraine headaches without focal neurological symptoms is a category 3, a condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
 - b. If migraines worsen in frequency or severity, or if focal neurological symptoms or signs (aura, visual changes, scotoma, flashing lights, dysphasia, numbness of face/extremities) occur, COCs must be discontinued. Women who develop focal neurological symptoms or signs should be referred promptly for neurologic evaluation. If a woman \geq 35 years old develops migraine headaches without aura or other neurological symptoms, COCs must be discontinued.

E. Seizure Disorders

1. A large majority of women with seizure disorders will notice no change in the frequency or severity of seizure activity as a result of initiating oral contraceptives.
2. Concurrent use of anti-seizure drugs that induce hepatic enzymes may reduce effective plasma steroid levels in oral contraceptive users. It is the responsibility of the provider to review a client's anti-seizure medication(s) for potential drug interaction with oral contraceptives.
3. Use of backup barrier methods, and the benefits and risks of using oral contraceptives in women with seizure disorders should be discussed with women who use anti-seizure drugs but who need a high degree of protection. Women who are on certain anti-seizure medications and choose to use oral contraceptives should be advised to use a back up method, such as condoms. Any breakthrough bleeding during this time may indicate a decrease in circulating levels of estrogen and progestin. Such a decrease could result in ovulation. Continued use of a barrier method with oral contraceptives (dual method use) or switching to Depo Provera or an IUD may be advised.

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F. Drug Interactions

1. Anti-seizure medications: Concurrent use of anti-seizure drugs that induce hepatic enzymes may reduce effective plasma steroid levels in oral contraceptive users. (See E. above). These medications include phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine (USMEC 2010).
2. Gabapentin (Neurontin®), vigabatrin, ethosuximide and lamotrigine (Lamictal®) have no effect on this enzyme system and do not interfere with contraceptive effectiveness. Valproate/ Valproic Acid (Depakote®) and felbamate (Felbatol®) do not increase breakdown of hormones and may even increase hormone levels. Pharmacokinetic studies show levels of lamotrigine decrease significantly during COC use. This may result in an increase in seizure activity (USMEC 2010).
3. Rifampin increases hepatic clearance of estrogens and progestins; it is recommended that clinicians not prescribe oral contraceptives for women on this drug (USMEC 2010).
4. **Broad-spectrum Antibiotics: Hormone levels in women using COCs are not lowered by the use of ampicillin, amoxicillin, clarithromycin, metronidazole, quinolones, doxycycline, tetracycline, or fluconazole. Virtually every COC user taking these antibiotics has hormone levels that remain well within the therapeutic range for contraceptive efficacy. As a result, back-up methods should not be necessary unless the client has problems taking her pills, e.g., if her underlying medical condition interferes with pill taking or absorption.** (Contraceptive Technology, 20th Edition, pp. 305)
5. COCs can decrease clearance of benzodiazepines such as diazepam (Valium), nitrazepine, chlordiazepine, alprazolam, which suggests the need for lower doses of these medications. Clearance of bronchodilators such as theophylline, aminophylline and caffeine as well as anti-inflammatory corticosteroids may also be reduced.
6. More rapid clearance of acetaminophen and aspirin is also reported.
7. The FDA has alerted providers that the use of St. John's Wort may decrease the therapeutic effect of COCs.
8. **Antiretroviral (ARV) drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. Limited data suggest potential drug interactions between many ARV drugs (particularly some NNRTIs and ritonavir-boosted protease inhibitors) and hormonal contraceptives. These interactions may alter the safety and effectiveness of both the hormonal contraceptive and the ARV drug. Thus, if a woman on ARV treatment decides to initiate or continue hormonal contraceptive use, the consistent use of condoms is recommended to both prevent HIV transmission and compensate for any possible reduction in the effectiveness of the hormonal contraceptive. When a combined oral contraceptive is chosen, a preparation containing a minimum of 30 ug ethinyl estradiol (EE) should be used.** (USMEC 2010)

VI. Guidelines for Oral Contraceptive Use and Management of Problems/Side Effects

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A. Missed Oral Contraceptive Pills/ Consideration of Emergency Contraception

Current research supports the belief that the greatest risk of pregnancy results from missing pills on either side of the week of spacer pills (COCs), thus extending the pill-free interval beyond 7 days. Therefore, pills missed mid-cycle are much less likely to result in pregnancy than pills missed just before or after the week of spacer pills. There is no pill free interval with progestin only pills (POPs); late or missing pills anytime in the cycle may pose a risk of pregnancy.

1. Women that are late taking a pill
 - a. Take the missed pill ASAP and take the next pill at the usual time.
 - b. No back-up method of birth control is necessary unless this one pill extends the pill-free interval.
2. Women that have missed 1 pill (>24 hours has elapsed since the last pill was taken).
 - a. Take both the missed pill and today's pill at the same time;
 - b. A back-up method of birth control should be used for 7 days after the pills are missed.
3. Women that have missed 2 pills (1 pill has been missed and the woman is late or has completely missed the second pill)
 - a. Take the last pill that was missed ASAP.
 - b. Take the next pill on time.
 - c. Throw out the other missed pills.
 - d. Take the rest of the pills in the package right on schedule.
 - e. A back-up method of contraception should be used for 7 days after the pills are missed.
4. Women that miss pills during the third week of pills (pills 15-21 or during the week before the spacer pills). (This is not relevant for progesterone only pill [POP] users.)
 - a. Finish the rest of the hormonal pills in the pack.
 - b. Do NOT take the spacer pills.
 - c. Start taking a new pack of pills as soon as the current pack is finished. Clients may not have a period until the end of the second pack of pills.
 - d. A back-up method of birth control should be used for 7 days.
5. Emergency contraception (ECP) should be considered for a woman who has missed oral contraceptives and had unprotected intercourse in the last 5 days.
 - a. Contraceptive Technology 19th Edition, p. 102, advises it is reasonable to offer ECP no matter how many pills have been missed if the woman is worried or wants to avoid even the smallest risk of pregnancy.

B. Extended Use or Continuous Cycling: Consider offering clients the opportunity of fewer withdrawal bleeds during the year by skipping the placebo pills for up to 4 packs in a row, particularly if they experience estrogen withdrawal symptoms such as headache when taking the placebo pills during the fourth week of the pill pack. The prescription

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needs to be written for 16-17 cycles/year. As an alternative to the more expensive products with dedicated packaging for extended use, select a monophasic pill for extended use or continuous cycling. Please refer to, *Contraceptive Technology*, 20th Revised Edition, pp. 292-294.

- C. Changing COCs and back-up methods.
1. There is no need for a back-up method when switching between brands unless pills have been missed or a client is being switched from a POP. If pills have been missed, follow the directions above.
 2. When switching, the client can be started on the new pill on the first day of the pill free interval.

VII. Progestin-only Pills (Mini-pills or POPs)

A pregnancy that does occur in a woman taking mini-pills is more likely to be ectopic. Some sources postulate that 10% of pregnancies that occur to mini-pill users are ectopic (*Contraceptive Technology*, 20th Edition, p.241).

A. Precautions

1. Refrain from providing progestin-only pills (POPs) for women with the following diagnoses:
 - a. Suspected pregnancy;
 - b. Breast cancer.
2. Exercise caution if POPs are used in the following situations and carefully monitor for adverse effects.
 - a. Certain anti-seizure medications or use of rifampin cause the liver to metabolize progestins more rapidly.
 - b. Breast cancer with a 5-year disease-free interval - some breast cancers are sensitive to progestins.
 - c. Liver conditions such as severe decompensated cirrhosis, adenoma or cancer, active viral hepatitis.
 - d. Current deep vein thrombosis.
 - e. History of bariatric surgery using malabsorptive procedures (Roux-en-y gastric bypass, billiopancreatic diversion).
 - f. Client develops ischemic heart disease, stroke or migraine headaches with aura while taking POP.
 - g. Positive or unknown antiphospholipid antibodies.
 - h. Client is using antiretroviral therapy.
3. Initiating progestin-only pills
 - a. Follow instructions for initiating combined oral contraceptives (COCs).
 - b. Progestin-only pills (POPs) may be started in non-lactating women at any time postpartum. It is probably acceptable to start a breast-feeding woman on POPs before six weeks postpartum if she desires, as long as

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breastfeeding has been established. The U.S. Medical Eligibility Criteria for Contraceptive Use lists POPs as a 2 (the advantages of using the method generally outweigh the theoretical or proven risks) for breastfeeding women less than one month post partum. (See Contraceptive Technology, 20th Edition, Chapter 18: Postpartum Contraception and Lactation, pp. 483-511)

VIII. Follow Up

- A. The new oral contraceptive user must be reassessed within three months after beginning the pill, and at least annually thereafter.
- B. Please refer to Section 1.4 – Health Care Services in the Nursing Manual for a complete review of the requirements for revisits for OCP users.
- C. At each oral contraceptive related medical visit (not to include routine supply visits), the client should be asked about changes in personal history, possible side effects, and her menstrual cycle/bleeding pattern.

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The following is a sample of a Hormonal Consent Form. This form can be downloaded from the CDPHE Family Planning Program website at: <http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665>

HORMONAL CONSENT	
• ORAL CONTRACEPTIVE (Combined and POP) • ORTHO EVRA • NUVARING	
I have been given information about and have had a chance to ask questions about:	
<input type="checkbox"/> Birth control pills: <input type="checkbox"/> Combined <input type="checkbox"/> Ortho Evra patch <input type="checkbox"/> NuvaRing <input type="checkbox"/> Progesterone Only	
I know that:	
<ul style="list-style-type: none">• Birth control pills and Ortho Evra patch do not require a back up method if I start on the first day of my period.• Progesterone only pills (POP) only have the hormone progesterone. This may make the effectiveness slightly lower than combined birth control pills. I know that I need to take a pill every day without a break. There is no hormone-free week like there is with combined pills. My periods might be irregular.• NuvaRing is left in the vagina for three weeks from the day I insert it, and is then removed and thrown away. A new ring is inserted one week (7 days) after removal of the old one.• Ortho Evra (the patch) results in a 60% increase in exposure to estrogen compared to the average birth control pill. It is not known whether this results in a significant increased risk of blood clots.• The hormonal methods listed above do not provide me with protection from sexually transmitted diseases. If I need this protection, I have been advised to use condoms PLUS this method.	
I have been told that there may be some medical risks when using any of the combined hormonal methods that could include such things as stroke, blood clots, or liver tumors. I have been given a copy of the "Detailed Patient Labeling" which tells how often these problems happen.	
I understand that the cardiovascular risks of this method may get worse with age, especially over 35 years of age, and with smoking. I know that the serious health problems that this method can cause are rare. I know to call the clinic or my private doctor, or to go to the emergency room if I have any of these danger signs:	
<ul style="list-style-type: none">• Severe abdominal pain;• Chest pain;• Severe headaches;• Changes in my vision;• Severe leg pain.	
If I wish to discontinue my method, I have been advised that it is better for me to finish the cycle I am taking before stopping the method. If I do not wish to become pregnant, I must start on another method immediately.	
_____	_____
Patient signature	Date
_____	_____
Staff signature	Date
Interpreter's Statement	
I have translated the information and advice presented orally to the client who has chosen:	
<input type="checkbox"/> Combined birth control pills <input type="checkbox"/> Progesterone only birth control pills <input type="checkbox"/> Ortho Evra Patch <input type="checkbox"/> NuvaRing	
I have also read the consent form to her in a language she understands and explained its contents to her. To the best of my knowledge and belief, she understands this explanation and voluntarily consents to the use of the method marked above.	
_____	_____
Interpreter's signature	Date

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The following is a sample of a Hormonal Evaluation Form. This form can be downloaded from the CDPHE Family Planning Program website at: <http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665>

HORMONAL METHOD EVALUATION ORAL CONTRACEPTIVES (Combined and POP), EVRA PATCH, NUVARING, IMPLANON (rod implant)	
Name _____	Today's date _____
Date of birth _____	Age _____
First day of last period _____	
1. Please check your current method:	
<input type="checkbox"/> Birth control pill (Combined)	<input type="checkbox"/> Birth control pill (Progesterone only)
<input type="checkbox"/> Evra	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Implanon	
2. Are you having any problems with your method? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____	
3. Do you have any questions? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____	
4. Have you had any health problems or seen a physician since your last visit? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____	
5. Are you taking any other medications? <input type="checkbox"/> No <input type="checkbox"/> Yes List: _____	
6. Check if you have had any of the following since you started your method:	
<input type="checkbox"/> Severe headaches	<input type="checkbox"/> Severe abdominal pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heavy bleeding
<input type="checkbox"/> Severe leg pain	<input type="checkbox"/> Weight gain
Client Signature _____	Date _____
TO BE COMPLETED BY STAFF	
S:	
O: B/P ____ WT ____	
A:	
P:	
Staff signature _____	Date _____

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The following is a sample of a Headache Evaluation Form. This form can be downloaded from the CDPHE Family Planning Program website at: <http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665>

Headache Evaluation Form				
Client # _____	Name _____	Age _____		
When you have headaches, how often do you..... (Circle one answer per question)				
1. Feel them coming on before they become headaches?	Never	Rarely	Usually	Always
2. Have moderate to severe pain?	Never	Rarely	Usually	Always
3. Have pulsating, pounding, or throbbing pain?	Never	Rarely	Usually	Always
4. Have worse pain on one side of your head?	Never	Rarely	Usually	Always
5. Have worse pain when you move, bend over or walk stairs?	Never	Rarely	Usually	Always
6. Have nausea?	Never	Rarely	Usually	Always
7. Have vomiting?	Never	Rarely	Usually	Always
8. Feel bothered by light?	Never	Rarely	Usually	Always
9. Feel bothered by sound?	Never	Rarely	Usually	Always
10. Need to limit or avoid daily activities?	Never	Rarely	Usually	Always
11. Want to lie down in a quiet, dark room?	Never	Rarely	Usually	Always
12. See zigzag lines, spots, or light flashes?	Never	Rarely	Usually	Always
To give your healthcare provider more complete information, please answer these additional questions:				
1. Do any immediate family members also suffer from headaches?		Yes	No	
2. In your lifetime, have you had at least 5 headaches with the symptoms noted above?		Yes	No	
3. At what age did you first experience these headaches?	_____			
4. On average, how often do you get these headaches?	_____			
5. Which medicine(s) do you take for your headaches?	_____			
Check all of the statements that are true:				
1. My headache medicine does not make me pain free.	_____			
2. My headache medicine does not treat other symptoms (e.g., nausea, sensitivity to light).	_____			
3. I take my headache medicine more than 2 or 3 times per week.	_____			
4. My headache medicine makes me drowsy.	_____			
5. I take more than one kind of medicine for my headaches.	_____			
6. My headache may last 4 to 72 hours (untreated or unsuccessfully treated).	_____			
Check any of the following that ever bring on one of these headaches:				
___ Intense lights, smells, or sounds	___ Too little sleep or too much sleep			
___ Weather changes	___ Missed meals			
___ Allergies or sinus pain/pressure	___ Lack of caffeine or too much caffeine			
___ Stress or tension	___ Changes in mood/excitement			
___ Monthly menstrual cycle/hormonal changes	___ Foods or alcoholic beverages			
Client's Signature: _____		Date: _____		
TO BE COMPLETED BY STAFF				
Assessment:				
_____ Clinician Signature	_____ Date	_____ Agency Name		