

HORMONAL BIRTH CONTROL METHOD EVALUATION

Name _____

Today's date _____

Date of birth _____

Age _____

First day of last period _____

Do you smoke cigarettes or use tobacco products?

No Yes

If "Yes", how many per day? _____

1. Please check your current birth control method:

- | | |
|--|--|
| <input type="checkbox"/> Birth control pill (estrogen and progestin) | <input type="checkbox"/> Birth control pill (progestin only) |
| <input type="checkbox"/> Birth control patch | <input type="checkbox"/> Vaginal ring |
| <input type="checkbox"/> Implant | <input type="checkbox"/> Birth control shot (depo) |

2. Please rate your birth control method, circle one:

 Fantastic  Good  OK  I need help with my method  I may need to change

Please explain: _____

3. Do you have any questions? No Yes

Explain: _____

4. Have you had any health problems since you started your birth control method? No Yes

Explain: _____

5. Have you seen a health care provider since your last visit? No Yes

Explain: _____

6. Are you taking any other medications? No Yes

Please list: _____

7. Check if you have had any of the following since you started your birth control method:

- | | |
|--|--|
| <input type="checkbox"/> Increase in headaches or 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 _____ N/A _____

A:

P:

Staff signature _____

Date _____