**Children’s Medical Group Oral Contraceptives Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_

1. Do you think you could be pregnant now?

Yes No

1. Do you have history of repeated headaches?

Yes No

1. Do you have high blood pressure?

Yes No

1. Do you have or had history of high cholesterol?

Yes No

1. Do you have history of inflammatory diseases such a Crohn’s or Lupus?

Yes No

1. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?

Yes No

1. Do you have diabetes?

Yes No

1. Do you have or had history of serious liver disease or jaundice (yellow skin or eyes)?

Yes No

1. Do you regularly take any pills for Tuberculosis (TB), fungal infections or seizures?

Yes No

1. Has it been more than 5 days since the beginning of your last menstrual period?

Yes No

Patient/Guardian Signature:­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­ Date: \_\_\_\_\_\_\_\_\_\_