NEW JERSEY HEALTH SCREENING QUESTIONNAIRE

Patient Name____ **Date**____/____/______

Patient Address____ **Date of Birth** ____/____/_____

Patient Telephone Number _____________________________________ **Height**____'____" **Weight**______**lbs.**

Name of your Primary Care Provider (PCP) or Reproductive Health Care Provider ______________________________

Provider Address ____

Provider Telephone Number ____

Approximate date that you last visited a PCP or Reproductive Health Care Provider___/___/______

Do you give consent for the pharmacy to contact your PCP or Health Care Provider? Yes______ No______

Please answer the following questions about your medical history[1]:

	PREGNANCY SCREEN		
1	Have you had a positive pregnancy test in the past weeks or are you experiencing pregnancy symptoms, which may include nausea, fatigue, or breast changes? If you answered YES, please STOP here.	Yes ☐	No ☐
2a	Did you have a baby in the last 6 months, are you breast feeding, *AND* have you had no menstrual period since delivery?	Yes ☐	No ☐
2b	Did you have a baby in the last 28 days?	Yes ☐	No ☐
2c	Did you have a miscarriage or abortion in the last 7 days?	Yes ☐	No ☐
2d	Did your last menstrual period start within the past 7 days?	Yes ☐	No ☐
2e	Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes ☐	No ☐
2f	Have you used a reliable contraceptive method consistently and correctly since your last menstrual period or delivery?	Yes ☐	No ☐
	MEDICAL HISTORY		
3	Are you getting your period regularly?	Yes ☐	No ☐
4	Is the reason you want to use a hormonal contraceptive to prevent pregnancy?	Yes ☐	No ☐
5	Have you ever had surgery? If so, list the type and date of your most recent procedure: _________________	___/___/_______	
6	Have you ever had a blood clot in the arms, legs, lungs, or other parts of the body? If so, list where and when: ________________	Yes ☐	No ☐
7	Have you ever been told by a health care provider that you are at risk of having a blood clot?	Yes ☐	No ☐
8	Do you have high blood pressure?	Yes ☐	No ☐
9a	Do you have diabetes? If you answered **NO**, skip to question 14.	Yes ☐	No ☐
9b	Have you had diabetes for more than 20 years?	Yes ☐	No ☐
9c	Do you have damage to your eyes, kidneys, nerves of the feet or hands, or any other organ from diabetes?	Yes ☐	No ☐
10	Do you have high cholesterol?	Yes ☐	No ☐
11	Have you ever had a heart attack or stroke, or been told you had heart disease?	Yes ☐	No ☐
	PLEASE TURN OVER		

[1] The information collected from this questionnaire is considered a "medical record" and protected under HIPAA.

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12	Do you use any form of tobacco, e.g., vape e-cigarette, e-hookah, or e-liquid, chew tobacco, dip snuff, nicotine patch or gum, or smoke cigarettes? If you answered **NO**, skip to the next question. If so, how much tobacco and what type do you use in a day? ____	Yes ☐	No ☐
13	Do you ever have headaches that start with flashes of light, blind spots, or tingling in your hands or face, that comes and goes away before the headache starts?	Yes ☐	No ☐
14	Have you had a recent change in vaginal bleeding that worries you?	Yes ☐	No ☐
15	Have you ever been diagnosed with polycystic ovary syndrome (PCOS) and/or other disorder? If yes, what disorder? ____	Yes ☐	No ☐
16	Have you had stomach reduction or weight loss surgery? If yes, describe what type? _____________________________	Yes ☐	No ☐
17	Do you have, or have you ever had, breast cancer?	Yes ☐	No ☐
18	Have you had a heart, liver, kidney, lung, or other organ transplant?	Yes ☐	No ☐
19	Do you have lupus?	Yes ☐	No ☐
20	Have you ever been diagnosed with any other chronic health conditions or diseases that might be related to an autoimmune disorder? If so, please list: ____________	Yes ☐	No ☐
21	Have you ever had hepatitis, liver disease, liver cancer, gall bladder disease, or jaundice (yellow skin/eyes)? If so, please specify: __________________________________	Yes ☐	No ☐
22	Do you have or have you ever had any other medical conditions that we have not discussed? Please list them here: ____	Yes ☐	No ☐
	MEDICATION HISTORY		
23	Do you take any medications, herbs, or supplements? Please list them here: ____	Yes ☐	No ☐
24	Have you had any allergies or bad reactions to any medication you have taken? Please list them here: ____	Yes ☐	No ☐
25a	Have you ever used birth control in the past? If **YES**, circle if you have used any of the following: birth control pills (progestin only or combined), the patch, vaginal ring, or self-administered injectable contraceptive. If **NO**, skip to Question 30.	Yes ☐	No ☐
25b	When was the last time you used birth control?	___/___/______	
25c	Have you ever had a bad experience with birth control? If yes, what was the experience? Nausea, hair loss, weight gain, headache or other? Please describe__________________	Yes ☐	No ☐
26	Is there a type of birth control that you would like to use? If **YES**, circle your response: birth control pills (progestin-only or combined), patch, vaginal ring, self-administered injectable contraceptive, or list any other below. ____	Yes ☐	No ☐
27	Have you taken emergency contraception in the last 5 days?	Yes ☐	No ☐
28	Have you ever been told by a health care provider not to take birth control pills (progestin-only or combined), the patch, vaginal ring, or self-administered injectable contraceptive? If so, which? ________________________________	Yes ☐	No ☐
29	Has anyone ever pressured you into using or not using contraceptives, or used violence or intimidation to control your contraceptive choice?	Yes ☐	No ☐

Pharmacist Internal Use Only

Patient Blood Pressure Reading____________________mmHg Date _________________________________

Pharmacist Name____

Pharmacy Name____

Phone_____________________________Address____

Notes ____