Date of visit: _________________

Contraceptive pick up – Assessment Form

This form is for use in between annual visits when patients are requesting contraceptive pick up/repeat depo injections of their current method of choice (patients wanting to change method/brand must complete a new intake form). All medications MUST be dispensed by a certified RN, Physician, or NP.

Name	
Date of birth/age	
Allergies	
Current phone number & email	

In the last year or since your last visit…	YES	NO	Clinician to review
are you smoking cigarettes?			
are you taking any daily medications or vitamins?			
have you started having headaches of any kind?			Review aura
have you been told you have any of the following? • heart disease/problem with your heart • liver disease/problem with your liver or gallbladder? • blood clot • abnormal bleeding • breast disease • high blood pressure • lupus			If yes, assess, consult and /or referral to physician/NP
is there a chance that you may be pregnant now?			Missed dose
since your last period have you missed a dose of your birth control (pill, patch, ring, injection)?			
have you had concerns or side effects with your current method of birth control? If yes, please specify:			ACHES
Do you wish to discuss any concerns about physical or sexual abuse/assault?			
Do you have any other questions or concerns you would like to discuss with clinic staff?			
CLINICIAN USE ONLY Blood pressure: _____ • BP should be repeated at 3- 6 months following initiation of all hormonal contraception and then at least annually • Health history reviewed			BP recorded in chart Initial:

Client Signature: ___________________ Clinician Signature: ___________________

Revised July 2012 by CM CoP – This form was developed by the Contraceptive Management Community of Practice as a template for clinic use. You may require approval from your employer prior to implementing.