

# ORAL CONTRACEPTIVE (OC) ASSESSMENT

Please check all that apply and use the space provided to explain your answers as needed.

Which OC are you currently using and for how long?

\_\_\_\_\_

YES NO

Are you satisfied with your current OC?

\_\_\_\_\_

Are you experiencing any side effects with your current OC?

\_\_\_\_\_

Do you have or have you ever had (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Severe high blood pressure            | <input type="checkbox"/> Undiagnosed vaginal bleeding |
| <input type="checkbox"/> High risk of blood clots              | <input type="checkbox"/> Kidney problems              |
| <input type="checkbox"/> Heart attack                          | <input type="checkbox"/> Liver problems               |
| <input type="checkbox"/> Stroke                                | <input type="checkbox"/> Adrenal problems             |
| <input type="checkbox"/> Certain cancers (eg, breast or liver) | <input type="checkbox"/> Other _____                  |

Do you have a family history of any of the above?

\_\_\_\_\_

Has any healthcare provider diagnosed you or a family member with a new condition since your last visit?

\_\_\_\_\_

Have you started taking any new medications, including long-term medications?

\_\_\_\_\_

Have you started smoking or changed your smoking habits since your last visit?

\_\_\_\_\_

Would you like information about protecting yourself against sexually transmitted diseases (STDs)?

\_\_\_\_\_

Please provide any other medically relevant information:

\_\_\_\_\_

Date

Name

Date of Birth

Weight

Date of last menstrual period

Reason for visit/call

Date of follow-up visit/call