



Assessment tool

Patient Information		
Name:	Height:	Blood pressure:
Age:	Weight:	
Date of birth:	Body mass index (BMI):	
Medical History		
1. Have you ever been diagnosed with breast cancer?	<input type="radio"/> Yes <input type="radio"/> No	Refer if yes
2. Have you ever had a stroke or problems with your heart?	<input type="radio"/> Yes <input type="radio"/> No	
3. Have you ever had a blood clot in your leg or lungs?	<input type="radio"/> Yes <input type="radio"/> No	
4. Do you have a bleeding disorder?	<input type="radio"/> Yes <input type="radio"/> No	
5. Do you have any of the following conditions? Check all that apply: <input type="checkbox"/> Migraine with aura (numbness, tingling, weakness, visual changes before or during the migraine) <input type="checkbox"/> Liver problems <input type="checkbox"/> High blood pressure $\geq 140/90$ mmHg <input type="checkbox"/> Lupus <input type="checkbox"/> Diabetes with microvascular complications <input type="checkbox"/> Uncontrolled high blood pressure (systolic BP > 160 mmHg or diastolic BP > 100 mmHg) <input type="checkbox"/> Undiagnosed abnormal vaginal uterine bleeding		Refer if applicable
6. Have you ever had weight-loss surgery?	<input type="radio"/> Yes <input type="radio"/> No	
Menstrual History		
7. When was the first day of your last menstrual period?	dd/mm/yyyy	
8. How would you describe your periods?	<input type="radio"/> Regular <input type="radio"/> Irregular	
9. If your periods are irregular, what is the longest you have ever gone without a period?		
10. What is the average number of days that your period lasts for?		
11. How would you describe your period flow?	<input type="radio"/> Heavy <input type="radio"/> Normal <input type="radio"/> Light	
Social History		
<i>Consider other options apart from combined oral contraceptives if patient is > 35 years of age and smokes ≥ 15 cigarettes per day.</i>		
12. Do you currently smoke cigarettes?	<input type="radio"/> Yes <input type="radio"/> No	
13. How many cigarettes do you smoke daily?	<input type="radio"/> < 15 <input type="radio"/> ≥ 15	
Possibility of Pregnancy and Breastfeeding		
<i>It is best practice to use progestin-only options while breastfeeding, as estrogen can decrease the amount of milk produced.</i>		
14. Have you given birth in the past 42 days?	<input type="radio"/> Yes <input type="radio"/> No	After birth, if there are no other risks, progestin-only options are safe.
15. Are you currently breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No	If breastfeeding, a 6-week wait is necessary before prescribing any of the combined oral contraceptives.

Financial contribution:

Canadian Pharmacists Association
Association des pharmaciens du CanadaHealth Canada
Santé Canada
CART-GRAC
 Contraception and Abortion Research Team
 Groupe de recherche sur l'accès à la contraception


Future Pregnancy Intention		
16. When do you want to be pregnant, if ever?	<input type="radio"/> <1 year <input type="radio"/> 1-2 years <input type="radio"/> 3-4 years <input type="radio"/> 5-10 years <input type="radio"/> Never	
17. How important is it for you not to get pregnant until then?	<input type="radio"/> Very important <input type="radio"/> Important <input type="radio"/> Unimportant	
Birth Control Experiences and Preferences		
<i>If an IUD, IUS or implant is the preferred and appropriate option, refer to health-care provider.</i>		
18. Have you ever used birth control in the past?	<input type="radio"/> Yes <input type="radio"/> No	
19. If yes, which options have you used? Check all that apply: <input type="radio"/> Combined oral pill <input type="radio"/> Condoms <input type="radio"/> Emergency contraception <input type="radio"/> Implant <input type="radio"/> Injection <input type="radio"/> IUD/IUS <input type="radio"/> Patch <input type="radio"/> Progestin-only pill <input type="radio"/> Vaginal ring		
20. Have you had side effects from using contraceptives?	<input type="radio"/> Yes <input type="radio"/> No	
21. If yes, what side effect(s) did you experience?		
22. Are you currently using a contraceptive option?	<input type="radio"/> Yes <input type="radio"/> No	
23. If yes, list the method you use:		
24. What is/are your preferred method(s)?		
Drug Interactions		
25. Do you take seizure medications?	<input type="radio"/> Yes <input type="radio"/> No	If yes, list the medication(s) that you take:
26. Do you take medications to treat tuberculosis?	<input type="radio"/> Yes <input type="radio"/> No	
27. Do you take medications to treat fungal infections?	<input type="radio"/> Yes <input type="radio"/> No	
28. Do you take medications for human immunodeficiency virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No	
Adherence		
29. Which strategy might you find helpful to improve adherence?	<input type="radio"/> Alarm or reminders on your phone <input type="radio"/> Pairing the timing of birth control with a daily/weekly ritual (e.g., after brushing teeth)	
Additional Comments		