EC Assessment CLIENT QUESTIONNAIRE

Name (first, last) _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth (Month / Day / Year) _____/_____/_____

1. Do you want to be pregnant now? (If "yes," you do not need to fill out the rest of this form) ___Yes ___No

2. When was the first day of your last menstrual period? Date: (Month / Day / Year) _____/_____/_____

3. Did your period come on time? _____Yes _____No

4. Was it the usual number of days and the usual amount of bleeding? _____Yes _____No

5. Why do you need emergency contraception?

_____ Recent unprotected sex or birth control failure

_____ Future need (if only for future need, skip to question #8)

6. Have you had unprotected sex during the last 120 hours? _____Yes _____No

If yes, when? Date: (Month / Day) _____ Time: _____ AM / PM (circle one)

7. Have you had other unprotected sex since your last menstrual period? _____Yes _____No

If yes, when? Date: (Month / Day) _____

8. Are you allergic to any drugs or medications? _____Yes _____No

9. EC is for emergency use only. For regular, long-term use other methods of birth control are better and more effective.

Would you like a referral for family planning services? _____Yes _____No

10. If you have any of the following you may have a sexually transmitted infection (STI) and should see a doctor:

- Burning with urination
- Vaginal discharge / itch
- Pelvic pain
- Partner with STI

- Abnormal vaginal bleeding
- Pain with sex

Would you like a referral to a doctor or clinic? _____Yes _____No

11. Condoms can help protect you from STIs and HIV / AIDS.

Do you want condoms or information about STIs and HIV / AIDS? _____Yes _____No

PHARMACIST USE ONLY

Client provided with: Referral made? Additional pharmacist notes / comments

☐ Key Facts sheet ☐ Contraception

☐ Consent sheet ☐ STD / HIV

☐ Instructions for Use ☐ Pregnancy

☐ EC counseling ☐ Primary Care

☐ EC product ☐ Sexual Assault/CPS

☐ Plan B

☐ Preven

☐ Ovral Pharmacist signature _____

☐ Other_____ Date: _____ /_____ /_____ Time: _____ AM / PM (circle one)

New Mexico Pharmaceutical Association recommended form (EC-2 May 2—3)