

EC PATIENT ASSESSMENT

Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth (Month / Day / Year): ____ / ____ / ____

Please answer the following questions:

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

____ / ____ / ____

2. Did your period come on time? Yes No

3. Was it the usual number of days and the usual amount of bleeding? Yes No

4. Why do you need emergency contraception?

- Recent unprotected sex or birth control failure
- Future need (*If only for future need, skip to question #6*)

5. Have you had unprotected sex during the last 5 days? Yes No

If yes, when? Date (*Month / Day / Year*): ____ / ____ / ____

6. Are you allergic to any medications or drugs? Yes No

If yes, please list: _____

The following advice to the patient is optional:

- EC is for emergency use only. For regular, long-term use other methods of birth control are better and more effective. You should consult your health care provider for further information.
- If you have any of the following you may have a sexually transmitted infection (STI) and should see a doctor: burning when urinating, vaginal discharge/itch, pelvic pain, partner has a STI, abnormal vaginal bleeding, or pain during sex. You should consult your health care provider or your local public health clinic as soon as possible.

FOR PHARMACIST USE ONLY:

Client provided with:

- Key Facts Sheet
- Consent Sheet
- EC Product
 - Plan B
 - Other _____

Referral Made for?

- Contraception
- STI / HIV
- Pregnancy
- Primary Care
- Sexual Assault
- Child Abuse (*Call DCYF 1-800-894-5533*)

Additional pharmacist notes/comments:

Date: ____ / ____ / ____

Time: ____ : ____ AM / PM (Circle One)

_____, R.Ph.
Pharmacist's Signature