Screening Form for Emergency Contraceptive Pills (ECPs)

First Name: ______________________________

Last Name: ______________________________

Address: ______________________________

____

Phone: ____________ Date of Birth: ____________

Current Medications:
(include nonprescription and herbal medications)

☐ none or ______________________________

Medical Conditions:

☐ none or ______________________________

Allergies:

☐ none or ______________________________

When was the first day of your last menstrual period (dd/mm/yy)?______________________________

Are your menstrual cycles regular (one menstrual period every month)? ☐ Yes ☐ No

Was your last menstrual period normal? ☐ Yes ☐ No

When did you most recently have unprotected sexual intercourse (i.e., the act of intercourse for which you are seeking emergency contraception)? Date____________ Time____________

Since your last menstrual period, have you had any other episodes of unprotected sex that might put you at risk of pregnancy?
☐ Yes ☐ No

Date____________ Time____________ Date____________ Time____________

Have you used emergency contraception in the last month? ☐ Yes ☐ No

Are you currently using another form of birth control? ☐ Yes ☐ No

If yes, which type?
(check all that apply)

- ☐ birth control pill
- ☐ diaphragm
- ☐ condom
- ☐ IUD
- ☐ spermicide
- ☐ injectable birth control
- ☐ sponge
- ☐ other____________________

☐ I would like to receive more information regarding ongoing methods of birth control.
(The pharmacist may follow-up at a later date to discuss this topic and to answer your questions.)

Pharmacist Use Only

☐ Plan B™ dispensed Date:______________ Follow-up Date:______________

☐ Referral Date:______________ Name:______________ Reason:______________

Counseled: ☐ Patient in person Time:____________ Pharmacist:______________

Notes: ______________________________

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