



Screening Form for Emergency Contraceptive Pills (ECPs)

First Name: _____ Last Name: _____ Address: _____ _____ Phone: _____ Date of Birth: _____	Current Medications: <i>(include nonprescription and herbal medications)</i> <input type="checkbox"/> none or _____ _____ _____
Medical Conditions: <input type="checkbox"/> none or _____ _____ _____ _____	Allergies: <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No Was your last menstrual period normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ Date _____ Time _____	
Have you used emergency contraception in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently using another form of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which type? <input type="checkbox"/> birth control pill <input type="checkbox"/> spermicide <i>(check all that apply)</i> <input type="checkbox"/> diaphragm <input type="checkbox"/> injectable birth control <input type="checkbox"/> condom <input type="checkbox"/> sponge <input type="checkbox"/> IUD <input type="checkbox"/> other _____ <input type="checkbox"/> I would like to receive more information regarding ongoing methods of birth control. <i>(The pharmacist may follow-up at a later date to discuss this topic and to answer your questions.)</i>	
Pharmacist Use Only <input type="checkbox"/> Plan B™ dispensed Date: _____ Follow-up Date: _____ <input type="checkbox"/> Referral Date: _____ Name: _____ Reason: _____ Counseled: <input type="checkbox"/> Patient in person Time: _____ Pharmacist: _____ Notes: _____ _____ _____	