

13. Have you had the Hepatitis B Vaccine Series? _____NO ___ YES

14. Age at last tetanus/diphtheria booster? _____ Don't know _____

15. Would you like to change your current method of birth control? ___ NO ___ YES

BELOW, PLEASE CHECK THE METHOD OF BIRTH CONTROL YOU ARE USING.

- ABSTAINING NOT USING ANY METHOD WITHDRAWAL DIAPHRAGM
 STERILIZATION OTHER _____ MALE OR FEMALE CONDOMS

HORMONAL METHODS:

- BIRTH CONTROL PILLS: Brand _____
 NUVARING® EVRA PATCH™ DEPO-PROVERA® (3 month injection)
 IMPLANON® (IMPLANT)

PLEASE ANSWER THESE QUESTIONS IF YOU ARE USING A HORMONAL METHOD.

| | NO | YES | Interviewer Comments |
|---|----|-----|----------------------|
| 1. Frequent or severe headaches? | | | |
| 2. Severe chest pain? | | | |
| 3. Difficulty breathing? | | | |
| 4. Swelling or pain in thigh or lower leg? | | | |
| 5. Visual disturbances? | | | |
| 6. Dizziness or fainting? | | | |
| 7. Breast Lump? | | | |
| 8. Bleeding between periods in past three months? | | | |
| 9. Missed periods? | | | |
| 10. Continual breast tenderness? | | | |
| 11. Severe abdominal pain? | | | |
| 12. Weight change of 10 pounds or more? | | | |
| 13. Other problems? | | | |

PLEASE ANSWER THESE QUESTIONS IF YOU ARE USING AN IUD/IUS.

IUD/IUS: Type _____ NO YES Interviewer Comments

| | NO | YES | Interviewer Comments |
|-------------------------------|----|-----|----------------------|
| 1. Bleeding between periods? | | | |
| 2. Can you feel the string? | | | |
| 3. Pain in the abdomen? | | | |
| 4. Pain with intercourse? | | | |
| 5. Chills or fever? | | | |
| 6. Unusual vaginal discharge? | | | |
| 7. Heavy increase in period? | | | |

I certify that the answers given are true and complete to the best of my knowledge.

Client's Signature _____ Date of Birth _____ Date _____

Interviewer's Signature _____ Clinician Signature _____