NHS Pharmacy Contraception Service – Emergency Contraception pre-consultation questionnaire

- **To provide emergency contraception safely, we need to ask you several questions. Please complete this form before your consultation with the pharmacist or pharmacy technician.**
- **When completing the form, please follow any instructions provided by the pharmacy team.**

***Note to the pharmacy team**: Anyone who is requesting emergency contraception for someone else (question 1) or answers 'Yes' to questions 2 or 3 must be referred to the pharmacist or pharmacy technician providing the service rather than completing the rest of the questions.*

Patient details

Name:		Date of birth:		Age:	
Address:		Postcode:			
		Telephone number:			
Email address:		NHS number: (If known)			
GP Practice:		Consultation date:			

Screening questions

1. **Are you wanting emergency contraception for yourself or someone else?** **If for someone else, please speak to the pharmacist or pharmacy technician before answering any further questions.*	☐ Myself	☐ Someone else*
2. **Have you given birth to a child within the last 21 days?** **If yes*, please *speak to the pharmacist or pharmacy technician before answering any further questions.*	☐ Yes*	☐ No
3. Have you had a miscarriage, an abortion, an ectopic pregnancy or a uterine evacuation for gestational trophoblastic disease (GTD) within the last 5 days? **If yes*, please *speak to the pharmacist or pharmacy technician before answering any further question*	☐ Yes*	☐ No

4. Why are you requesting emergency contraception? *(tick all that apply)*

☐ Had unprotected sexual intercourse ☐ Regular contraception has been compromised (e.g. condom split)
☐ Regular contraception used incorrectly (e.g. missed my pill or had a problem with my pill e.g. bout of sickness which may render it ineffective)
☐ Vomited within 3 hours of emergency contraception
☐ Other (please detail):

5. Have you had unprotected sex within the last 120 hours (5 days)?	☐ Yes	☐ No
6. Have you had unprotected sex earlier in this menstrual cycle?	☐ Yes	☐ No
7. Do you have menstrual periods?	☐ Yes	☐ No
8. Was you last period late, lighter or shorter or unusual in any way?	☐ Yes	☐ No
9. What was the first day of your last period?	Date:	
10. What is the average length of your cycle?	Number of days:	
11. Have you used an emergency contraceptive pill before?	☐ Yes	☐ No
12. If yes, did you have any adverse reaction to it? If yes, please detail:	☐ Yes	☐ No

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13. Have you already used an emergency contraceptive pill since your last period?	☐ Yes	☐ No
14. Do you use a contraceptive pill or any other form of contraception?	☐ Yes	☐ No
15. If you use a contraceptive pill, in your current pack, have you missed any of your pills or had any problems with your contraceptive pill that may affect its effectiveness?	☐ Yes	☐ No
16. Are you taking or have you recently taken any other prescribed or supplied medication, including short term medication (e.g. antibiotics)?	☐ Yes	☐ No
17. Are you taking any over the counter medicines, herbal products or supplements?	☐ Yes	☐ No
18. Do you have any allergies? If yes, please list them:	☐ Yes	☐ No
19. Are you pregnant, or might you be pregnant?	☐ Yes	☐ No
20. Are you breastfeeding?	☐ Yes	☐ No
21. What is your weight (*The pharmacy team can weigh you if you are unsure*)?		***Pharmacy use*** BMI:
22. What is your height (*The pharmacy team can measure you if you are unsure*)?		
Gastro-intestinal health		
23. Do you suffer from acute/active inflammatory bowel disease or Crohn's disease?	☐ Yes	☐ No
24. Do you suffer from Lapp-lactase deficiency?	☐ Yes	☐ No
25. Do you have hereditary problems of galactose intolerance?	☐ Yes	☐ No
26. Do you suffer from glucose-galactose malabsorption?	☐ Yes	☐ No
27. Do you have any form of liver disease or liver impairment?	☐ Yes	☐ No
Other health conditions		
28. Have you been diagnosed with Acute porphyria?	☐ Yes	☐ No
29. Do you suffer from severe asthma?	☐ Yes	☐ No

Thank you for completing this form. Please return it to the pharmacist or pharmacy technician when you are ready.