



CLIENT ASSESSMENT

Name (first, last) _____ Phone _____

Address _____ City _____ State ____ Zip Code _____

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 five days? ___Yes ___No
If yes, when? Date: (Month / Day) ____/____ Time: _____ AM / PM (circle one)
6. Are you allergic to any drugs or medications? ___Yes ___No

The following questions are optional:

7. EC is for emergency use only. For regular, long-term use other methods of birth control are better and more effective.
Would you like a referral for family planning services? ___Yes ___No
8. If you have any of the following you may have a sexually transmitted infection (STI) and should see a doctor: burning with urination, vaginal discharge / itch, pelvic pain, partner has a STI, abnormal vaginal bleeding, or pain with sex.
Would you like a referral to a doctor or clinic? ___Yes ___No
9. Condoms can help protect you from STIs and HIV / AIDS.
Do you want condoms for future use? ___Yes ___No

PHARMACIST USE ONLY

Client provided with:	Referral made?	Additional pharmacist notes / comments
<input type="checkbox"/> Key Facts sheet	<input type="checkbox"/> Contraception	
<input type="checkbox"/> Consent sheet	<input type="checkbox"/> STI / HIV	
<input type="checkbox"/> Instructions for Use	<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> EC product	<input type="checkbox"/> Primary Care	
<input type="checkbox"/> <i>Plan B</i>	<input type="checkbox"/> Sexual Assault /	
<input type="checkbox"/> <i>Preven</i>	<input type="checkbox"/> CPS	
<input type="checkbox"/> <i>Other</i> _____		
<input type="checkbox"/> Condoms provided		

Date: ____/____/____ Time: _____ AM / PM (circle one) Pharmacist signature _____