

CLIENT ASSESSMENT

Name (first, last) _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Date of Birth Date: (month / day / year) ____/____/____

Please answer the following questions:

1. When was the first day of your last menstrual period?

Date: (month / day / year) ____/____/____

2. Why do you need emergency contraception?

____ Recent unprotected sex or birth control failure

____ Future need (if only for future need, skip to question #4)

3. Have you had unprotected sex during the last 5 days? ___Yes ___No

If yes, when? Date: (month / day) ____/____ Time: _____ AM / PM

4. Are you allergic to any drugs or medications? ___Yes ___No

Optional Question:

5. Condoms can help protect you from Sexually Transmitted Infections and HIV / AIDS. Do you want condoms for future use? ___Yes ___No

PHARMACIST USE ONLY

<p>Client provided with:</p> <p><input type="checkbox"/> Key Facts sheet</p> <p><input type="checkbox"/> Consent sheet</p> <p><input type="checkbox"/> Instructions for Use</p> <p><input type="checkbox"/> EC product</p> <p style="padding-left: 20px;"><input type="checkbox"/> <i>Plan B</i></p> <p style="padding-left: 20px;"><input type="checkbox"/> <i>Preven</i></p> <p style="padding-left: 20px;"><input type="checkbox"/> <i>Other (specify):</i></p> <p style="padding-left: 20px;">_____</p> <p><input type="checkbox"/> Condoms provided</p> <p>Date: ____ / ____ / ____ Time: ____ AM / PM (circle one)</p>	<p>Additional pharmacist notes / comments:</p>
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Pharmacist signature: _____