Combined hormonal contraceptives (CHC) questionnaire

Name:	
Date of birth & age:	/ / Age =
Name of contraception:	
Your pharmacy:	

Smoking status:	☐ Never smoked ☐ Ex-smoker → when did you stop? → ☐ Current smoker → typically how many per day? →	

Observations:	Blood pressure:	Weight:	Height:

1	Has University Health Service prescribed contraception for you previously?	☐ No	☐ Yes
2	Have you had an organ transplant?	☐ No	☐ Yes
3	Have you had hypertension (raised blood pressure)?	☐ No	☐ Yes
4	Have you had ischaemic heart disease?	☐ No	☐ Yes
5	Have you had vascular disease? (eg peripheral vascular disease, claudication, stroke, TIA)	☐ No	☐ Yes
6	Have you had a blood clot? (ie DVT, VTE)	☐ No	☐ Yes
7	Has any first-degree relative (eg mum, dad, brother or sister) had a blood clot?	☐ No	☐ Yes
	If yes, what was the youngest age anyone got their first clot?	☐ 45+	☐ < 45
8	Have you had major surgery in the last 4 weeks, are a wheelchair user or immobile?	☐ No	☐ Yes
9	Are you known to have Factor V Leiden, prothrombin, protein S, protein C or antithrombin mutations?	☐ No	☐ Yes
10	Have you had valvular heart disease?	☐ No	☐ Yes
11	Have you had congenital heart disease?	☐ No	☐ Yes
12	Have you had cardiomyopathy?	☐ No	☐ Yes
13	Have you had an arrhythmia like atrial fibrillation or long QT?	☐ No	☐ Yes
14	Have you had a migraine?	☐ No	☐ Yes
	If yes, did the migraines start before or after you started taking contraception?	☐ Before	☐ After
	If yes, did you have aura before or during the migraines? (eg flashing lights, sparkles, stars, blind or coloured spots, tunnel vision, zigzag lines, taste change, speech change, etc)	☐ No	☐ Yes
15	Have you had idiopathic intracranial hypertension?	☐ No	☐ Yes
16	Do you have epilepsy?	☐ No	☐ Yes
17	Do you have or have you had breast cancer?	☐ No	☐ Yes
18	Has any family member been diagnosed with BRCA 1 or 2 mutations?	☐ No	☐ Yes
19	Do you have any gallbladder disease?	☐ No	☐ Yes
20	Are you currently suffering an acute hepatitis attack or flare up?	☐ No	☐ Yes
21	Have you had liver disease?	☐ No	☐ Yes
22	Have you had SLE or antiphospholipid antibodies?	☐ No	☐ Yes

23	Do you take any of these drugs:	aprepitant bosentan carbamazepine efavirenz eslicarbazepine	fosphenytoin lumacaftor modafinil nevirapine oxcarbazepine	phenobarbital phenytoin primidone rifabutin rifampicin	ritonavir rufinamide St John's wort topiramate	☐ No	☐ Yes

Please sign	Signature:	Date: