Injectable depot contraception questionnaire

Please use this form for Depo-Provera & Sayana Press

Name:	
Date of birth & age:	/ / Age =
Contraception:	☐ Sayana Press (self-given) ☐ Depo-Provera (nurse-given)
Destination pharmacy: (for Sayana Press)	

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

Observations:	Your blood pressure:	Your weight:
		Your height:

1	Has University Health Service prescribed this contraception for you previously?	☐ No	☐ Yes
Cardiovascular history			
2	Are you diabetic?	☐ No	☐ Yes
3	Do you have raised blood pressure?	☐ No	☐ Yes
4	Do you have raised cholesterol or triglycerides?	☐ No	☐ Yes
5	Is your BMI > 30 (your height in metres divided by your weight in kgs squared (m/kg^2)	☐ No	☐ Yes
6	Are you a current smoker?	☐ No	☐ Yes
Vascular disease			
7	Have you had ischaemic heart disease?	☐ No	☐ Yes
8	Have you had peripheral vascular disease, claudication or retinopathy?	☐ No	☐ Yes
9	Have you had a transient ischaemic attack or stroke (TIA or CVA)?	☐ No	☐ Yes
Other factors			
10	Do you have any unexplained vaginal bleeding?	☐ No	☐ Yes
11	Do you have or have you had breast cancer?	☐ No	☐ Yes
12	Have you had liver disease?	☐ No	☐ Yes
13	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

If you have answered yes to any of the above questions, please tell us more:

Please sign	Signature:	Date: