New Start (never used birth control) $35
New Consult or DEPO Injection $20
Renewals (every 6 months) $10

Lynn Oaks Compounding Pharmacy

HORMONAL CONTRACEPTION RECORD, SCREENING AND PATIENT CONSENT

SECTION A: Information about person to receive hormonal contraception (please print)

Name (Last, First, Middle Initial)	**Date of Birth** / /	**1st Date of Last Menstrual Period** / /
Address **City** **State** **Zip Code**		**Phone Number** ( )
Physician Name	**Physician Phone Number** ( )	**Allergies**

SECTION B: The following questions will help determine which birth control will be given today.	**YES**	**NO**
Birth Control Questions		
1a. Have you ever taken birth control pills, or used a birth control patch, ring or shot/injection? (if no, go to question 2)	☐	☐
1b. Did you ever experience a bad reaction to using hormonal birth control?	☐	☐
1c. Are you currently using birth control pills, or a birth control patch, ring or shot/injection?	☐	☐
2. Have you ever been told by a medical professional not to take hormones?	☐	☐
3. Do you smoke cigarettes?	☐	☐
4. Do you think you might be pregnant?	☐	☐
5. Have you given birth within the past 6 weeks?	☐	☐
6. Are you currently breastfeeding an infant who is less than 1 month of age?	☐	☐
7. Do you have diabetes?	☐	☐
8. Do you get migraine headaches, or headaches so bad that you feel sick to your stomach, you lose the ability to see, it makes it hard to be in light, or it involves numbness?	☐	☐
9. Do you have high blood pressure, hypertension or high cholesterol?	☐	☐
10. Have you ever had a heart attack or stroke, or been told you had any heart disease?	☐	☐
11. Have you ever had a blood clot in your leg or in your lung	☐	☐
12. Have you ever been told by a medical professional that you are at a high risk of developing a blood clot in your leg or in your lung?	☐	☐
13. Have you had bariatric surgery or stomach reduction surgery?	☐	☐
14. Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	☐	☐
15. Do you have or have you ever had breast cancer?	☐	☐
16. Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	☐	☐
17. Do you have lupus, rheumatoid arthritis, or any blood disorders?	☐	☐
18. Do you take medication for seizures, tuberculosis (Tb), fungal infections, or human immunodeficiency virus (HIV). If yes, list them here:	☐	☐
19. Do you have any other medical problems or take regular medication? If yes, list them here:	☐	☐

SECTION C: Please read the following statements and sign below on the signature line.

I have read or have had explained the information provided about the birth control I am about to receive. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of birth control and ask that the birth control be furnished to me or to the person named above for whom I am authorized to make this request.

SIGNATURE - Person to receive birth control or person authorized to sign on the patient's behalf X	**Date Signed**

SECTION D: DO NOT WRITE BELOW THIS LINE - FOR PHARMACY ONLY

☐ Eligible for Pharmacist Services ☐Refer Patient to: _____	**Blood Pressure _____/_____** **Record of visit given to** ☐ patient ☐ HCP:_____

Birth Control: **#**

SIG: **Refills:**

SIGNATURE AND TITLE - Person furnishing birth control X	**Printed Name -** Person furnishing birth control	**Date**

Address: Lynn Oaks compounding Pharmacy, 2220 Lynn Rd. #100 Thousand Oaks, CA 91360 Phone: (805) 495-1015