

Questionnaire for low dose oral contraceptive pills

Name _____ Age _____ Height _____ Weight _____ Single _____ Married _____

1. Do you smoke? Yes · No
If so, how many cigarettes do you smoke per day? _____
2. Have you ever had any allergic reactions (oral contraceptive pills or hormone pills) ? Yes · No
3. Do you have a family history of breast cancer? Yes · No
4. Have you ever found lumps on your breasts? Yes · No
5. Have you experienced irregular bleeding? Yes · No
6. Do you have shortness of breath, chest pains, headaches, fatigue, swelling, vision problems or speech impairment?
Yes · No
7. Have you ever had thrombophlebitis, lung thrombosis, cerebrovascular accident or coronary artery? Yes · No
8. Have you ever had congenital thrombosis? Yes · No
9. Do you have a family history of thrombosis? Yes · No
10. Please check the following if you've ever experienced;
 Antiphospholipid antibody syndrome
 High blood pressure
 Autoimmune disease
 Diabetes
 Malignant disease
 Hyperlipidemia
 Hemolytic
 Hypohydration
 Cystocele
 Severe infection
11. Have you ever had a miscarriage or still born birth? Yes · No
12. Have you ever had high blood pressure? Yes · No
13. Have you ever had high blood pressure during pregnancy? Yes · No
14. If you ever became pregnant, have you had jaundice, constant pain or herpes during pregnancy? Yes · No
15. Are you planning to have(or had)major surgery? Yes · No
16. Are you pregnant now or possibly pregnant? Yes · No
17. Have you delivered a baby lately? Yes · No
18. Have you ever had heart disease or kidney problems? Yes · No
19. Do you have hyperlipidemia? Yes · No
20. Do you have diabetes? Yes · No
21. Have you ever had liver disease? Yes · No
22. Have you ever had epilepsy or experienced numbness? Yes · No
23. Are you under doctor's care? Yes · No
24. Are you taking any medications or supplements? Yes · No
25. Do you wear contact lenses? Yes · No