SOGC

Contraception questionnaire

Date: _____ Patient ID: _____

1. How old are you? _____

2. Have you experienced any of the following situations? Select all that apply:
   - ☐ Had a pregnancy scare from missing a pill
   - ☐ Forgot to use contraception
   - ☐ Did not use contraception because it was inconvenient
   - ☐ None of these have happened to me

3. Have you ever gotten pregnant while using a method of birth control? If yes, select all that applied:
   - ☐ No
   - ☐ Yes, while using a combined hormonal contraceptive (pill, patch, ring)
   - ☐ Yes, while using a progestin-only contraceptive (pill, needles)
   - ☐ Yes, while using a copper intrauterine contraceptive (copper IUC)
   - ☐ Yes, while using a hormonal intrauterine contraceptive (hormonal IUC)
   - ☐ Yes, while using a barrier method (condom, diaphragm)
   - ☐ Yes, while using natural family planning (withdrawal, calendar method)

4. Would an unintended or mistimed pregnancy be devastating for you?
   - ◯ Yes ◯ No

5. Are you planning to get pregnant soon?
   - ◯ No
   - ◯ Yes, within one year
   - ◯ Yes, in more than one year
   - ◯ Not sure

6. Are you looking for a permanent (non-reversible) birth control option?
   - ◯ Yes ◯ No

7. Are you comfortable with hormones as part of your contraception plan?
   - ◯ Yes ◯ No ◯ Not sure

8. With oral contraceptives, a pill must be taken every day at the same time in order to be at its maximum effectiveness. Are you able to take a pill at the same time every day?
   - ◯ Yes ◯ No

9. Do you need a contraception method that is easy to keep private?
   - ◯ Yes ◯ No

10. Injections are used to administer some forms of contraception. Would you be ok with receiving a needle four times a year?
    - ◯ Yes ◯ No

11. Do you have acne or excessive unwanted facial hair growth?
    - ◯ Yes ◯ No

12. Do you have heavy or painful periods?
    - ◯ Yes ◯ No

13. If it was possible to avoid having periods, would you want to avoid them?
    - ◯ Yes ◯ No

14. Do you chew/smoke/vape nicotine/tobacco?
    - ◯ Yes ◯ No

15. Have you ever been diagnosed by a physician or nurse practitioner with one or more of the following conditions? Select all that apply:
    - ☐ High blood pressure (treated or not)
    - ☐ Deep vein thrombosis/pulmonary embolism (blood clots in your veins or your lungs)
    - ☐ Stroke or heart attack
    - ☐ Migraine headache with aura
    - ☐ Breast cancer
    - ☐ I have not been diagnosed with any of these conditions

You can also invite your patients to visit **www.itsaplan.ca** to fill out this questionnaire on their own.

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