Name _____
Date of Birth _____
Date _____

Be Well Women's Health
Family Planning Questionnaire (FPQ)

Which birth control option is right for you?

Have you ever used birth control? YES NO When was the last time? _____

Types Used and Dose	For how long?	Adverse Reactions	Why did you stop using?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been pregnant? YES NO

Have you gotten pregnant while on birth control? YES NO Which method? _____

Will you possibly plan another pregnancy in the future? YES NO If so, when? _____

Are you interested in permanent sterilization? (Never want another pregnancy) YES NO

Are you interested in learning more about natural family planning? (Calendar or rhythm method) YES NO

Do you smoke (tobacco)? NO YES If yes, how many packs per day? 2 1 half For how many years? _____

Do you or anyone in your family have a **blood clotting disorder**? YES NO

Have you or anyone in your family had **breast cancer**? YES NO If yes, who? _____

Do you have – (circle all that apply)

Liver disease (ex. Hepatitis) Migraine headaches High blood pressure Lupus

Any other medical problems? _____

_____

Which method do you think is right for you? _____

What else would you like your doctor to know about your birth control needs? _____

_____

_____

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