C.O.P.E.

Contraceptive Options Prior to Exam

Please be aware the information submitted here becomes a permanent part of your medical record

Prior use of hormonal contraception? ☐ Yes ☐ No

If Yes, When?

Any Problems with this method? ☐ Yes ☐ No

If yes, describe

Any previous Pregnancy? ☐ Yes ☐ No

If yes, when?

Prior PAP smear? ☐ Yes ☐ No

If yes, when?

Prior screening for sexually transmitted infection? ☐ Yes ☐ No

If yes, when?

Do you have or have you ever had any of the following conditions:

Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Mother or sister with breast cancer	☐ Yes	☐ No
Migraine with visual change, numbness or one-sided weakness	☐ Yes	☐ No
Parent or sibling with history of a blood clot	☐ Yes	☐ No
History of gastric surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Breast cancer or breast lump	☐ Yes	☐ No
Hepatitis or liver disease	☐ Yes	☐ No
Blood clot	☐ Yes	☐ No
Symptomatic gall bladder disease	☐ Yes	☐ No
Smoking over age 30	☐ Yes	☐ No
Lupus	☐ Yes	☐ No

Please Explain any **Yes** answers below:

Do you have any other significant medical problems? ☐ Yes ☐ No

If yes, describe:

Do you take any of the following medications:

Lamotrigine (Lamictal)	☐ Yes	☐ No
Rifampin	☐ Yes	☐ No
Rifabutin	☐ Yes	☐ No
Phemobarbitol/barbituates (Lumina, Barbita, Solfoton)	☐ Yes	☐ No
Primidone	☐ Yes	☐ No
Phenytoin	☐ Yes	☐ No
Carbamazepine (Tegretol)	☐ Yes	☐ No
Felbamate (Felbatol)	☐ Yes	☐ No
Topiramate (Topamax)	☐ Yes	☐ No
Vigabitrin (Sabril)	☐ Yes	☐ No

Are you currently taking any additional medications?

If yes, which one(s)?

Any problem with previous use of contraceptive, please describe

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many per day?

Are you interested in quiting? ☐ Yes ☐ No