

# Icebreaker

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Medications:  
(include non-prescription and herbal medications)

None or \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Conditions:

None or \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:

None or \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was the first day of your last menstrual period (dd/mm/yy)? \_\_\_\_\_

Are your menstrual cycles regular (one menstrual period every month)?  Yes  No

Was your last menstrual period normal?  Yes  No

When did you most recently have unprotected sexual intercourse (i.e. the act of intercourse for which you are seeking emergency contraception)? Date \_\_\_\_\_ Time \_\_\_\_\_

Since your last menstrual period, have you had any other episodes of unprotected sex that might put you at risk of pregnancy?

Yes  No

Date \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Have you used emergency contraception in the last month?  Yes  No

Are you currently using another form of birth control?  Yes  No

If yes, which type?

- |  |   |
|--|---|
| <input type="checkbox"/> Birth control pill        | <input type="checkbox"/> Spermicide               |
| <input type="checkbox"/> Diaphragm                 | <input type="checkbox"/> Injectable birth control |
| <input type="checkbox"/> Intrauterine System (IUS) | <input type="checkbox"/> Sponge                   |
| <input type="checkbox"/> Intrauterine Device (IUD) | <input type="checkbox"/> Condom                   |
| <input type="checkbox"/> Other _____               |   |

I would like to receive more information regarding ongoing methods of birth control.