Pharmaceutical Society of Australia

Emergency Contraception (EC) checklist

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To help us ensure the emergency contraception medicine is safe and suitable for you, please fill out the sections on this form. Your answers will be treated with the utmost privacy.

Date: .... **Name:** .... **Your age:** .... **years**

Usual means of contraception

☐ Oral contraceptive pill

☐ Condoms

☐ Rhythm Method

☐ None

☐ Other: ....

Reason for needing emergency contraception

☐ Contraceptive failure (e.g. split condom)

☐ Missed pill(s), or recent episode of diarrhoea or vomiting

☐ Sexual assault

☐ Contraception not used

Hours since last unprotected sex: ....

Information about your cycle

First day of bleeding of your last menstrual period

Date: ....

Usual number of days in cycle: .... days.

Was your **last period normal**?

☐ Yes ☐ No – it was ☐ lighter ☐ shorter

DId it last the usual number of days?

☐ Yes ☐ No

Have you had unprotected sex at any other time since the first day of your last period?

☐ Yes ☐ No

Have you had a pregnancy test recently (e.g. in the last two months)?

☐ Yes – Date tested: ....

☐ No

Do you think you may be pregnant already?

☐ Yes ☐ No

Your health

Do you have any of the following medical conditions?

☐ Breast cancer

☐ Unexplained vaginal bleeding

☐ Crohn's disease

Are you taking any **medicines** at the moment?

☐ Prescribed medicines

☐ Over-the-counter medicines from a pharmacy

☐ Medicines from a health food store or supermarket

Please name the medicines you take

....

....

....

Do you have any of these **symptoms**?

☐ Burning or pain when passing urine

☐ Lower abdominal pain

☐ Pain during or after sex

☐ Unusual vaginal discharge

☐ Irregular vaginal bleeding or spotting

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