EMERGENCY CONTRACEPTION

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:** **BMI:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	
Vaccination history:	

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Are you currently pregnant?	☐	☐	☐
Have you had unprotected or inadequately protected sexual intercourse within the last 5 days? *If yes, please indicate if it has been more than 72 hours:*	☐	☐	☐
Do you have any allergies or hypersensitivity to Levonorgestrel or any other medication? *If yes, please specify:*	☐	☐	☐
Have you had any persistent irregular bleeding/ lower abdominal pain?	☐	☐	☐