

**CHECKLIST FOR EACH RETURN VISIT
FOR WOMEN USING PILLS**

Before you are seen by a counselor or clinician, please tell us your response to the following questions. Please check yes or no. Tell us if you have:

- Any problem you think could be caused by pills Yes _____ No _____
- Nausea or Vomiting Yes _____ No _____
- Spotting or irregular vaginal bleeding Yes _____ No _____
- Occasional missed periods (no bleeding) Yes _____ No _____
- Breast tenderness or a breast lump Yes _____ No _____
- Any symptoms of pregnancy Yes _____ No _____
- Depression, severe anxiety or mood changes Yes _____ No _____
- Decreased interest in sex Yes _____ No _____
- Decreased ability to have orgasms Yes _____ No _____
- Gained 5 pounds or more Yes _____ No _____
- High blood pressure Yes _____ No _____
- Been smoking at all Yes _____ No _____
- Been taking medicines for seizures Yes _____ No _____
- Been taking over the counter herbs Yes _____ No _____
- Ever forgotten to take your pills Yes _____ No _____
- Forgotten to take pills quite often Yes _____ No _____
- Changed sexual partners Yes _____ No _____
- Experienced any of the following pill danger signals:
 - Abdominal pain? Yes _____ No _____
 - Yellow skin or eyes? Yes _____ No _____
 - Chest pain? Yes _____ No _____
 - Headaches which are severe? Yes _____ No _____
 - Eye problems: blurred vision or loss of vision? Yes _____ No _____
 - Severe leg pain? Yes _____ No _____

“ACHES” is a way for you to remember the pill danger signals.

Please explain any question you have answered “yes” to: