|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **No** | **Yes** | If **YES**, note according to body system below.  Include onset and outcome (if resolved) dates, severity grade, medications taken, and any comments relevant to the diagnosis/description. |
| 1 | Does the participant have any health problems? |  |  |
| 2 | Has the participant ever been hospitalized for any reason other than giving birth? |  |  |
| 3 | Has the participant ever had surgery, including a hysterectomy? |  |  |
| 4 | In the past year, has the participant been to the emergency room? |  |  |
| 5 | Has the participant had any medical or health problems in the past year, and if so, what was the underlying problem or diagnosis? |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Has the participant ever experienced any significant medical problems involving the following organ/systems?** | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | **No** | | | **Yes** | | | **Onset Date** | | | **Outcome Date** | | | **Severity Grade** | | | **Med. Taken?** | | | **Comments** | | |
|  | 1 | Head, Eyes, Ears, Nose and Throat (HEENT) |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 2 | Lymphatic |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 3 | Cardiovascular |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 4 | Respiratory |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 5 | Liver |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 6 | Renal |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 7 | Musculoskeletal |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 8 | Neurologic |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 9 | Skin |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 10 | Endocrine/Metabolic |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 11 | Hematologic |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  | | **No** | | | **Yes** | | | **Onset Date** | | | **Outcome Date** | | | **Severity Grade** | | | **Med. Taken?** | | | **Comments** | | |
|  | 12 | Cancer |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 13 | Allergies |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 14 | Mental Illness |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 15 | Alcohol / Recreational Drug Use |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 16 | STI/RTI (HPV, HSV, GC/CT, Syphilis, Trichomoniasis, Candidiasis, PID) |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  |  |  |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | 17 | OB/GYN (genital bleeding not associated with menses or childbirth, uterine fibroids, abnormal PAP, genital infection, hysterectomy e.g. uterus, at least one ovary) |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
| Are there any other health issues? | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |
| Any contraindication to progestin-only contraceptive method? (*Refer to U.S. Medical Eligibility Criteria for Contraceptive Use*) | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |
| **In the past 6 months have you experienced any of the following genital symptoms?** | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | **No** | | | **Yes** | | | **Onset Date** | | | **Outcome Date** | | | **Severity Grade** | | | **Med. Taken?** | | | **Comments** |
|  | Genital/vaginal burning | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Genital/vaginal itching | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Genital/vaginal pain during sex | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Post-coital bleeding (bleeding after sex) | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Genital/vaginal pain not during sex | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Abnormal genital/vaginal discharge | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Unusual genital/vaginal odor | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |
|  | Dysuria | | | |  | | |  | | |  | | |  | | |  | | |  | | |  |