**Contraceptive Pill Review**

In order to provide the contraceptive pill safely, we need to ask you a number of questions. We would be grateful if you could complete this form when you submit your next repeat prescription request. Failure to complete this review and provide an up to date BP reading on an annual basis could significantly delay your prescription.

If you are having any problems with your medication or would like to consider alternative contraception options, please speak to one of our Practise nurses, who will be able to advise you, or refer you to a GP as appropriate.

**You have been asked to complete this form because we do not have a recent Blood Pressure reading for you (last 12 months). Please arrange to visit the surgery (Mon – Fri 08.30 – 18.30) and use our BP machine situated in reception and hand your reading to our reception team who will record in your notes.**

**Patients Name: Date of Birth:**

**Contact Number: Today’s Date:**

(That you are happy for us to contact you on)

1. Are you a smoker? Yes  No
2. If **YES** how many do you smoke per day? ---------------Per day
3. Would you like help giving up? Yes  No
4. What is your weight approximately? ----------------------KG

1. **Are you aware:**
2. How the pill works? Yes  No
3. What to do if you miss a pill? Yes  No
4. That the contraceptive pill may not work if you have diarrhoea,

have been vomiting or are on antibiotics. Yes  No

1. That the contraceptive pill does NOT protect you from sexually

transmitted infections, so you will need to use a condom as well to

protect yourself. Yes  No

1. **Do you:**
2. Suffer from migraines? Yes  No

If so, do you experience visual symptoms or changes in sensation

or muscle power on one side of your body? Yes  No

1. Have parents or siblings who have had heart disease

or strokes under the age of 45? Yes  No

1. Have diabetes? Yes  No
2. Have you had a deep vein thrombosis or pulmonary embolus? Yes  No
3. Have parents or siblings that have had a deep vein

thrombosis or pulmonary embolus under the age of 45? Yes  No

1. Have any blood clotting illnesses/abnormalities? Yes  No
2. Have any family history of breast cancer under the age

of 50? Yes  No

**Thank you for completing this form, please return by email to** [**hwccg.afhc@nhs.net**](mailto:hwccg.afhc@nhs.net) **or hand into reception, please remember we require a blood pressure reading every 12 months.**

**If there are any problems with re-issuing your prescription we will contact you.**