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**ANNUAL MEDICATION REVIEW OF CONTRACEPTIVE PILLS**

Please complete the following questionnaire to the best of your ability. If you are unsure of any answers to any of the questions then kindly make either a telephone or face to appointment with one of the practice doctors or nurses so we can complete annual safety checks before you can continue the pill for a further year.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** | | |  | | | | | |
| **Date of Birth:** | | |  | | **NHS No (if known):** | | |  |
| **Address:** | | |  | | | | | |
|  | | | | | | | | |
| **Tel No:** | | |  | | | **Mobile No:** |  | |
| **Email Address:** | | |  | | | | | |
|  | | | | | | | | |
| **All questions marked with an \* must be answered** | | | | | | | | |
|  | | | | | | | | |
| **1.** | | | | | | | | |
| 1\* | Since your last medication review a year ago, have you been diagnosed with clots in your legs or lungs? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 2\* | Stroke or mini stroke? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 3\* | Heart Disease? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 4\* | Clots in legs or lungs among siblings or parents under the age of 45 years? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 5\* | Immobilised from broken bones etc? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 6\* | Migraine? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 7\* | Breast or womb cancer? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 8\* | Depression? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| Please provide further information, if known, by answering the following questions: | | | | | | | | |
|  | | | | | | | | |
| 1. | What is your current weight in kilograms (kg)? | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
| 2. | What is your current blood pressure? | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
| 3. | Do you currently Smoke? | | | | | | | |
|  | Choose an item. | | | | | | | |
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|  |  |  | | | | | | |
| 4. | Date of last period, if known (of cycle) | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
| 5. | Are you happy with the current pill? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 6a. | Have you had any problems or side-effects whilst taking the contraceptive pill? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 6b. | If you have answered YES please describe your problems/ side-effects: | | | | | | | |
|  |  | | | | | | | |
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| 7. | Do you take the pill regularly? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
| 8. | Would you like to discuss the coil, implant or the Depo injection? | | | | | | | |
|  | Choose an item. | | | | | | | |
|  |  |  | | | | | | |
|  |  |  | | | | | | |
|  | Today’s Date: | | |  | | | | |

**ACTION NOW REQUIRED:**

Please save this questionnaire to your PC and email it to [trentvalley.secretaries@nhs.net](mailto:trentvalley.secretaries@nhs.net).

Alternatively, if you do not have access to email, print a copy and post/ bring to the surgery.

Thank you