****

 **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. |
|  |  |  |
|  |  |  |
| 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:  |
|  |  |
|  |
|  |
|  |  |  |
| 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.

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

Thank you