We would be grateful if you could complete and return this form.

**Date:**

**PATIENT DETAILS:**

**Name: Date of Birth:**

**Contact Telephone Number: (to allow us to contact you if there are any queries)**

**Preferred Pharmacy:**

In order to provide the contraceptive pill safely we need to ask you a number of questions.

**Yes/No**

|  |  |
| --- | --- |
| 1. Have you had your blood pressure checked recently?

Record readings on the table below |  |
| 1. Are you a smoker?

If yes how many per day? |  |
| 1. Are you an ex smoker?

If yes when did you stop? |  |
| 1. What is your weight approximately?
 |  |
| 1. What is your height approximately?
 |  |
| 1. Are you aware:
 |  |
| 1. How the pill works?
 |  |
| 1. What to do if you miss a pill?
 |  |
| 1. That the contraceptive pill may not work if you have

Diarrhoea or have been vomiting? |  |
| 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?
 |  |
| 1. Do you suffer from migraines?
 |  |
| 1. Do you have parents or siblings who have had heart disease or strokes under the age of 45?
 |  |
| 1. Do you have diabetes?
 |  |
| 1. Have you ever had a deep vein thrombosis or pulmonary embolism?
 |  |
| 1. Do you have parents or siblings that have had a deep vein thrombosis or pulmonary embolism under the age of 45?
 |  |
| 1. Do you have any blood clotting illnesses / abnormalities that you are aware of?
 |  |
| 1. Do you have any family history of breast cancer under the age of 50?
 |  |
| 1. Are you aware of the alternatives such as long acting reversible contraception?
 |  |
| 1. Would you like to book a consultation with a nurse to discuss or arrange fitting of a long acting reversible contraceptive?
 |  |
| 1. Is your bleeding pattern acceptable to you?
 |  |

If there are any problems with re-issuing your prescription we will contact you. Otherwise your prescription will be processed with 2 working days and sent to your usual pharmacy.

Please take three readings in the morning and three readings at night and record in table below. If possible please leave 20 minutes between each reading.

|  |  |  |
| --- | --- | --- |
| **Time taken** | **Morning** | **Night** |
|  |  |  |
|  |  |  |
|  |  |  |