Hall Green Surgery

Oral Contraceptive Pill
Medical Assessment Form

Dear Patient: Please complete this form to the best of your understanding and bring with you to your next review of the contraceptive pill.

Patient Name: _____

Patient Date of Birth: _____Age: _____

Name of the pill currently prescribed: _____

Patient Weight (kg): _____Patient Height (cm)_____BMI(kg/m_2):_____
*If unsure these measurements can be recorded at your appointment

Smoker: YES/ NO/EX-SMOKER (Please delete those that are not applicable)

If 'YES': How many cigarettes do you smoke daily? _____
If 'EX-SMOKER: What date did you give up smoking? _____

Are you taking any other regular medications including over the counter (if known) please list:

_____
_____
_____
_____

Have you been taking the pill daily?	YES	NO
Please indicate if you have missed any pill?	YES	NO
If 'YES': How many pill have you missed?		
: Is there a possibility of pregnancy?	YES	NO
If 'NO': have you done a pregnancy test?	YES	NO
When was your last menstrual period?		
Have you had any irregular bleeding?	YES	NO
If 'YES', please make an appointment to see a Dr.		
Do you have any history of Deep Vein Thrombosis (DVT) or pulmonary embolism (PE)?	YES	NO
If 'YES' please make an urgent appointment to see a Dr.		
Have you noted a new onset of headache since being started on the pill?	YES	NO
If 'YES', please make an appointment to see a Dr.		
Do you have a history of heart problems?	YES	NO

For Health Professional to complete:

Blood pressure check:	mmHg
Missed pill rule discussed:	
LARC offered : Declined/ Accepted	