REVIEW FOR WOMEN TAKING ORAL CONTRACEPTIVE PILLS

Name ………………………………………………………………………… Date of Birth ……………………………………

**Patients up to 49yrs old** – complete yellow form yearly if no problems.

Telephone number which you are happy for us to contact you on ………………………………………..

Date you need your next supply of contraceptives ………………………………………………………………..

You have recently requested a repeat prescription of your contraceptive pills, your annual review is now due. If you don’t have any problems with your contraceptive pill it may not be necessary for you to see the doctor and instead you may just complete this form fully and return it to us as soon as possible. We do need to know your **height, weight and blood pressure.** You can check these without an appointment in our Health Information Room at the surgery (once COVID restrictions are lifted). Just come to the surgery any time between 08.00 and 18.00 Monday to Friday and ask the receptionist to direct you the room. It should only take you five minutes!

Once we have processed the information on this form we will decide whether you can pick up a prescription for a further 12 month supply of pills, or whether the doctor wishes to see you in which case we will issue a prescription for one month supply of the pill with a request to make an appointment. Occasionally the doctor will need to speak to you before issuing any more pills. It is therefore helpful if we can have mobile or home phone number on which you are happy for us to leave a voicemail/text/answerphone message. If you have not heard from us in a week you should be able pick up your next prescription.

* Name of contraceptive you are taking ……………………………………………………………………….

Do you think you are getting any side effects from the pill? □ Yes □ No

Are you breast feeding? □ Yes □ No

Are you immobile (ie. In a wheelchair)? □ Yes □ No

Do you suffer from migraines? If yes, □ Yes □ No

Do your migraines provoke loss of vision, numbness, weakness,

or speech problems?

Do you have breast lumps? □ Yes □ No

Do you take drugs for epilepsy or tuberculosis (TB)? □ Yes □ No

Have you ever had a blood clot in your leg or lung? □ Yes □ No

Has a close relative ever had a blood clot in the leg or lung? □ Yes □ No

Have you ever had a stroke or mini stroke (TIA)? □ Yes □ No

Do you smoke? □ Ex-Smoker □ Never smoked □ Smoker ……….. per day

**Please note – we advise all smokers that they should stop smoking.** Smoking does increase the risks of circulatory problems, particularly in women on the pill. If you would like to stop smoking ask reception for the self-referral information to quit smoking services.

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| More women are becoming interested in using **long-acting reversible contraceptives** (contraception you don’t need to remember). Please see **www.nhs.uk** website for further information (injections, implants and ‘coils’). If you would like to consider one of these methods please make an appointment with your Doctor. |

We do recommend that all women should be breast aware – if you would like information about checking your breasts please read information on **www.nhs.uk**. If you think you have a breast lump, or you have a strong family history of breast cancer and have not previously discussed this, please make an appointment with your doctor.

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| * Your Height ……………….. (cm)
* Your Weight ………………. (kg)
 | Please staple Blood Pressure Printout here |

We usually prescribe 12 packets of the pill. If you would prefer a different amount of packs please state the number required and reason for it here ………………

Yours signature ………………………………………………………………… Date ………………………………………..

**THANK YOU. PLEASE PUT THE COMPLETED FORM IN THE POST BOX BY THE FRONT DOOR**

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| BMI …………………….. DATA INPUT COMPLETED BY …………………. DATE ……………………………..All items to be prescribed generically unless specified□ Issue 12m prescription□ issue 1m prescription, routine review – patient notified by phone/voicemail/text/answerphone/text□ urgent review – patient notified by phone/voicemail/text/answerphone/letter |