**Glenfield Surgery**

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Annual Pill Check review

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| This form is for patients who simply require a further prescription of their contraceptive pill. If you have any concerns **DO NOT** use this form but book an appointment with a Nurse. Please complete the required information using the scales and blood pressure machine in the waiting area and we will issue a prescription to the nominated Chemist. It will take **24hrs** to generate your prescription.  **There is a slightly higher risk of developing breast cancer, cervical cancer, having a heart attack or stroke and developing a blood clot in the leg or lung in ladies taking the combined oral contraceptive pill. This risk is minimal but patients should be made aware of this** | | | |
| **Personal Details** | **Patient to complete all shaded areas:** | | |
| Title/Full name: | **Blood pressure reading**  (Please use the machine in the waiting area)  **Reading:** | | |
| Date of Birth: |
| Contact Telephone Number(s): | **Weight (in Kgs):**  **(Please see conversion chart)** | | |
| Height: | **Do you smoke? Current smoker [ ]**  **(please tick one Ex-Smoker [ ]**  **box only) Never smoked [ ]** | | |
| **Nominated Pharmacy:** | **Name of requested contraceptive pill:** | | |
| **Most women are interested in using long-acting reversible contraceptives.**  **Please go to** [**www.fpa.org.uk**](http://www.fpa.org.uk) **to read more information about these methods.** | | | |
| **MEDICAL HISTORY** | | | |
| Please circle your answers. If you answer **yes** to any of the following questions, we may contact you to discuss further. | | | |
| Have you had any problems or concerns with the pill? | | | Yes/No |
| Do you suffer from migraines? | | | Yes/No |
| Do you have a family or personal history of DVT or pulmonary embolism? | | | Yes/No |
| Have you had any irregular bleeding such as between periods or after sex? | | | Yes/No |
| Are you breast-feeding? | | | Yes/No |
| Signature of Patient: | | Date: <Today's date> | |
| ***For office use: (please tick)***   * BMI >35kg/m² BMI: <Latest BMI> * On medication for Epilepsy or T.B * Age >35 and current smoker * BP >140 systolic or >90 diastolic * Any YES answers in medical history or YES to above, show to usual GP otherwise,   Issue a prescription for 12 months [ ]  Or  Sent to usual GP [ ] | | ***For office use:***  Signed: ……………………………….  Assessing Technician  Date: …………………………………. | |