

Glenfield Surgery

Annual Pill Check review

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: <Patient Name>	Blood pressure reading (Please use the machine in the waiting area) Reading:
Date of Birth: <Date of Birth>	
Contact Telephone Number(s): <Patient Contact Details>	Weight (in Kgs): (Please see conversion chart)
Height: <Latest 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 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>
<p><u>For office use: (please tick)</u></p> <ul style="list-style-type: none"> <input type="radio"/> BMI >35kg/m² BMI: <Latest BMI> <input type="radio"/> On medication for Epilepsy or T.B <input type="radio"/> Age >35 and current smoker <input type="radio"/> BP >140 systolic or >90 diastolic <input type="radio"/> Any YES answers in medical history or YES to above, show to usual GP otherwise, <p>Issue a prescription for 12 months [] Or Sent to usual GP []</p>	<p><u>For office use:</u></p> <p>Signed:</p> <p>Assessing Technician</p> <p>Date:</p>