REVIEW FOR WOMEN TAKING ORAL CONTRACEPTIVE PILLS

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

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. We attach a prescription for one packet of your pills because your annual review is now due. If you have no 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 within the next two weeks. We do need to know your **weight and blood pressure.** You can check these without an appointment by using the scales and blood pressure machine at the surgery. Just come to the surgery any time between 08.00 and 18.30 Monday to Friday . It should only take you five minutes!

If you would rather see the doctor for your annual review, please make an appointment with the doctor and bring the completed form to the appointment with you.

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 a further 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 can 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 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 please ask a receptionist for QUITready stop smoking service number.

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| More women are becoming interested in using long-active reversible contraceptives (contraception you don’t need to remember) such as implants, coils etc. For more information on any other methods you may be interested in please call **0300 124 0102** Leicestershire sexual health services. |

**We do recommend that all women should be breast aware – if you would like information about checking your breasts please pick up a leaflet from reception. 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.**

**Are you experiencing domestic violence? Do you know of someone who is experiencing abuse and may need help and support? T**he Freephone 24 Hour National Domestic Violence Helpline s a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf. The Helpline can give support, help and information over the telephone, wherever the caller might be in the country. The Helpline is staffed 24 hours a day by fully trained female helpline support workers and volunteers. All calls are completely confidential. **Call 0808 2000 247**

* Your Weight ………………………. (kg)
* Your Height ………………………. (ft & in/cms)
* Your blood pressure reading …………………………… from the print out

We usually prescribe 6 months / packets of the pill and you will need a GP review every 12 months.

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

**THANK YOU. PLEASE HAND THE COMPLETED FORM TO RECEPTION**

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| BMI …………………….. DATA INPUT COMPLETED BY …………………. DATE ……………………………..All items to be prescribed generically unless specified□ Issue 6m prescription□ issue 1m prescription, routine review – patient notified by phone/voicemail/text/answerphone/text□ urgent review – patient notified by phone/voicemail/text/answerphone/letter |