Name……………………………………………….

Date of Birth ………………………………………

Postcode………………………………………......

Mobile Tel No…………………………………......

**Contraceptive Pill Review**

To ensure we are prescribing safely please complete this form. This will save you making face to face appointment with a clinician if you would prefer a call. This questionnaire only applies to contraceptive reviews. It cannot be used for pill starts. Please check you **blood pressure and weight** on the POD then complete this form and return to our reception team who will book a convenient telephone consultation.

Q1 Smoking status. I am a;

* Never smoker
* Current smoker of ……….cigarettes / ……….grams of tobacco a day
* Ex smoker. I stopped ……….days / months / years ago

Q3 Medical conditions. Since my last review;

* There has been no change to my health
* I have developed the following new medical conditions / problems

……………………………………………………………………………

Q4 My family’s health. Since last review

* There has been no change to my family’s health
* A first degree relative (parent or sibling) has developed a deep vein thrombosis OR pulmonary embolism OR stroke OR heart disease OR I’m not sure.

Q4 Since my last review I have noticed

* No changes
* I am bleeding between periods
* I am bleeding after sex
* My periods have become irregular

Q5 Since my last review

* I take no additional medications (from my GP, pharmacist or health food shop)
* I now take these new medications / herbal products

……………………………………………………………………………………………

Q6 Some contraceptives are not safe if you have / have had migraines

* I have never experienced a migraine
* I do suffer / have suffered from migraines

Q6 Tick box(s) if you would like to discuss:

* Long acting reversible contraceptives (implant / coil / injection).
* What to do if I miss my pill
* Sexually transmitted infections
* Alternative contraceptive options
* Cervical cancer (smear) screening
* Something else ………………………………………………………………..