Name………………………………………………..

Date of Birth ……………….Postcode……………

Mobile Tel No…………………………………........

**Contraceptive Pill Review - For Women Over 18years Of Age**

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 your **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. Name of contraceptive pill...................................................

Q2 Smoking status. I am a;

* I have never smoked
* I am a current smoker of ……….cigarettes / ……….grams of tobacco a day
* I am an 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, brother or sister) has developed a deep vein thrombosis (DVT) **or** pulmonary embolism (PE) **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 new 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 (a type of headache)

* 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 (STIs) / Getting myself tested for STIs
* Alternative contraceptive options
* Cervical cancer (smear) screening
* Something else ………………………………………………………………..