**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 [ ]OrSent to usual GP [ ] | ***For office use:*** Signed: ……………………………….Assessing Technician Date: …………………………………. |