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 ………………………………………………………………..

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

* 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? □ Yes □ No

If ‘yes’ do your migraines cause loss of vision, numbness,

weakness, or speech problems? □ Yes □ No

Do you have breast lumps? □ Yes □ No

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

Are you diabetic ? □ Yes □ No

Have you ever had breast cancer ? □ Yes □ No

Do you have a family history of breast cancer? □ Yes □ No

Do you have heart disease ? □ Yes □ No

Do you have gallstones? □ Yes □ No

Have you ever had liver problems? □ Yes □ No

Do you take St John’s Wort ? □ Yes □ No

Do you smoke? □ Ex-Smoker □ Never smoked □ Smoker ……….. per day

If you are taking the combined (21 day) pill is your □ Yes □ No

bleeding regular ?

If you are taking the progesterone only (mini) pill

is your bleeding acceptable? □ Yes □ No

Do you have any bleeding between periods or

after sex? □ Yes □ No

**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 the nurse or receptionist for the local ‘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. Would you like information about these methods ? (injections, implants and ‘coils’). Yes □ No □If you would like to consider one of these methods please make a telephone appointment with a GP. |

We do recommend that all women should be breast aware –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.

 Blood Pressure

* Height ……………….. (cm)

* Weight ………………. (kg)

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| Completed PrescriptionWhen your prescription is ready, you can either collect it from us, the local chemist (Lloyds Stoney Stanton) can collect on your behalf, or we can send it electronically to the chemist of your choice if you have been registered for electronic prescriptions. Please indicate your choiceCollect from reception □ Send electronically to …………………………………………………Lloyds to collect □ |

Patient Signature ………………………………………………………………………… Date ………………………………