***Elsdale Street surgery***

**Contraceptive Pill Repeat Prescription Request**

**NAME OF CONTRACEPTIVE PILL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **MEASURE** | **RESULT & DATE** |
| **BLOOD PRESSURE**  (can get checked in local pharmacy) |  |
| **WEIGHT**  (can use scales in waiting area of the surgery |  |
| **Height** |  |

**We cannot issue the oral contraceptive pill form without a recent blood pressure reading.**

**If you cannot check your blood pressure elsewhere please use the machine in reception before submitting this form.**

Please confirm your smoking status:

I have never smoked\_\_\_\_\_\_\_\_

I currently smoke \_\_\_\_\_\_\_\_\_\_ per day

I used to smoke \_\_\_\_\_\_\_\_\_ per day.

Date I stopped smoking: \_\_\_\_\_\_\_\_\_\_

If the above results are judged to be unsafe for continuation of the medication, you will be asked to see a practice nurse.

Please answer all questions on the form by ticking the relevant box, sign and date the form and hand to reception. Incomplete forms will not be processed. If you are unsure how to answer, please organise for appointment with a practice nurse.

|  |  |  |
| --- | --- | --- |
| **QUESTION** | **YES** | **NO** |
| Was the contraceptive pill first issued within the last 3 months? |  |  |
| Do you have any problems with your general health? |  |  |
| Do you have any problems or side effects using your contraceptive pill? |  |  |
| Do you understand the ‘missed pill rules’ for your particular type of contraceptive? |  |  |
| Do you have any health matters you wish to discuss with the GP or practice nurse? |  |  |
| Do you believe there is a chance you could be pregnant? |  |  |
| Have you ever suffered migraines / severe headaches / frequency headaches? |  |  |
| Have you ever suffered from visual or auditory disturbance prior to getting a headache? |  |  |
| Have you suffered vaginal bleeding between periods? |  |  |
| Have you suffered vaginal bleeding during or after sexual intercourse? |  |  |
| Have you suffered unusual discharge since last prescribed? |  |  |
| Have you had a history of blood clots or blood clotting disease? |  |  |
| Have you ever suffered from cancer? |  |  |

**Declaration: I understand that the contraceptive pill has certain risks associated with its use, as outlined in the patient leaflet previously provided with my pills, and that smoking increases these risks. The information provided is correct to the best of my knowledge.**

|  |  |
| --- | --- |
| **NAME (BLOCK CAPITALS)** | **DATE OF BIRTH** |
| **ADDRESS** | |
| **SIGNATURE** | **DATE** |

**A leaflet will be provided with you prescription that discusses long acting contraceptive options, please contact the medical centre and ask for an appointment if you wish to discuss this further.**