BUSHLOE SURGERY
Annual Pill Check Review

Date Received

Thank you for completing this form. We are aiming to avoid the need for you to see a clinician in order to re-issue your pill prescription. Once completed, please hand the form to reception and we will generate your next 12 month supply of the contraceptive pill. Scales and a blood pressure machine can be found in the waiting area – we are unable to issue a repeat prescription without up to date blood pressure and weight measurements. **Please allow 7 working days for us to check and issue your prescription.**

PERSONAL DETAILS					
Full Name			Telephone Number		
Mr/Mrs/Miss/Ms/Other			Work Number		
Address and Postcode			Mobile Number		
			E-mail Address		
Date of Birth					
Height	Feet/inches	cm	Weight	Stones/lbs	kg
Blood Pressure Reading 1 (Please use the machine next to the patient lift, at the surgery. Take 2 readings ,5 minutes apart)			Blood Pressure Reading 2		

MEDICAL HISTORY	
Please circle or tick 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
Are you breast feeding?	Yes / No
Do you suffer from migraines?	Yes / No
Do you have a family or personal history of DVT or pulmonary embolism?	Yes / No
Are you currently taking any weight-loss medications?	Yes / No
Have you had any irregular bleeding?	Yes / No

Do you smoke? (please tick 1 box only)	Current Smoker	Ex-Smoker	Never Smoked

How often do you have an alcoholic drink? (please tick 1 box only)	Never	Monthly or less	2-4 times per month
	2-3 times per week	4+ times per week	
How many standard* alcoholic drinks do you have on a typical day when you are drinking? (please tick 1 box only)	1-2 drinks	3-4 drinks	5-6 drinks
	7-9 drinks	10+ drinks	
How often do you have 6 standard* alcoholic drinks on one occasion? (please tick 1 box only)	Never	Less than monthly	Monthly
	Weekly	Daily or almost daily	

* A standard alcoholic drink is 1 unit of alcohol – a small glass of wine, a pub measure of spirits or ½ pint of lager/beer

Name of requested contraceptive pill:	
Signature of patient:	Date:
For office use: **Issue repeat prescription for 12 months:** ☐ **Issue repeat prescription for 1 month and then review:** ☐ **Needs review with GP:** ☐ **Needs review with Practice Nurse:** ☐	Signed: …… (GP/Nurse) Date: ……