PILL CHECK FORM FOR WOMEN TAKING ORAL CONTRACEPTIVE PILLS

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| **C O V I D – P A T I E N T I N F O R M A T I O N I N S T R U C T I O N S****PLEASE NOTE** * Please provide blood pressure readings (by either purchasing a machine from your local pharmacy or borrowing a BP machine from ourselves), we will then be able to prescribe a 12 month supply of medication (subject to there not being any problems). This is preferable.
* If you cannot provide BP readings, then a 6 month supply will be given.
* Please note any information or questions not completed may delay your prescription.
* BP readings can usually be done in the surgery (please speak to reception), however if you need to loan a machine for 24 hours or you have your own BP machine at home, you may email the form back to us at Alpine.house@nhs.net or via post at 86 Rothley Road, Mountsorrel, Loughborough, Leics. LE12 7JU .
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| **P L E A S E C O M P L E T E:-****Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Blood Pressure** *(please tick as appropriate):-* [ ] I have not provided BP readings. [ ] I have borrowed a BP machine from Alpine House or have used my own machine.Please take 3 successive BP readings and write them below:-1. 2) 3)

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**Name** ………………………………………………………………………… **Date of Birth** ……………………………………

**First appointment for oral contraceptive pill start** – Telephone call with clinician

**Patients up to 30yrs old** – complete pill check form as normal

**Patients 30-45yrs** – telephone call with a clinician every 3yrs for a pill check

**Patients over 45** – telephone call with a clinician on a yearly basis

Telephone number which you are happy for us to contact you on ………………………………………..

Date you need your next supply of contraceptives ………………………………………………………………..

Name of contraceptive you are taking …………………………………………………………………………………..

Please do ‘DIY’ bloods pressure check and height and weight on our machines down the corridor from reception. Please then fill in the following questions regarding your health.

Do you think you are getting any side effects from the pill? □ Yes □ No

Are you breastfeeding? □ Yes □ No

Are you immobile (i.e. in a wheelchair)? □ Yes □ No

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Do you suffer from migraines? If yes, □ Yes □ No

Do your migraines provoke loss of vision, numbness, weakness,

or speech problems?

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

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

**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 Quit Ready offers free and confidential text, phone and web chat advice for more details please call 0345 646 66 66 or visit www.quitready.co.uk

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| More women are becoming interested in using long-active reversible contraceptives (contraception you don’t need to remember. You can find information regarding long acting reversible contraceptives on the NHS choices website.If you would like to consider one of these methods please make an appointment with your Doctor. |

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.

You can find information relating to breast lumps and self-examination on the NHS choices website.

There is a slightly higher risk of developing breast cancer, having a heart attack or stroke, and developing blood clot in the leg or lung in ladies taking combined oral contraceptive pill. This risk is minimal but all patients should be made aware of this.

Sign Name ………………………………………………………………………. Date .………………………………………..

Print Name ………………………………………………………………………. DOB ..……………………………………….

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| BMI …………………….. DATA INPUT COMPLETED BY …………………. DATE ……………………………..All items to be prescribed generically unless specified□ Issue 12m prescription □ Issue 6m prescription □ Issue 1m prescription, routine review – patient notified by phone/voicemail/text/answerphone/text□ Urgent review – patient notified by phone/voicemail/text/answerphone/letter |