HEATH LANE SURGERY

APPENDIX 1

ANNUAL 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: _____

You have recently requested a repeat prescription of your contraceptive pills. You can request a prescription for one packet of your pills (if required) because your annual review is now due. If you have no problems with your contraceptive pill it may not be necessary for you to see the doctor or nurse and instead you may just complete this form fully and return it to us within the next two weeks. We do need to know your **height, weight and blood pressure**. You can check these without an appointment at the surgery or at home.

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

Once we have processed the information on this form, we will decide whether you can pick up a prescription for a further 6 month supply of pills, or whether the nurse wishes to see you in which case we will issue a prescription for a further one month supply of the pill with a request to make an appointment. Occasionally the nurse will need to speak to you before issuing any more pills. It is therefore essential that we have a telephone number on which you are happy for us to contact you. If you have not heard from us in a week you can pick up your next prescription.

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 provoke loss of vision / numbness / weakness or speech problems?

_____

Do you have any allergies/allergies to medication	Yes ☐	No ☐

(If yes, please specify)

_____

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 ☐

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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 thinking of having a baby in the next year? Yes ☐ No ☐

Do you have any family history of Heart disease in a close relative under age of 55 (man) or 65 (woman)? Yes ☐ No ☐

Do you smoke? Ex-smoker ☐ Date stopped: _____

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 please ask a receptionist to sign post you to the stop smoking service.

More women are becoming interested in using long-active reversible contraceptives. An information leaflet is attached about these methods (injections, implants and coils). If you would like to consider one of these methods please make an appointment with your doctor / nurse.

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.

Your height _____ (cm)

Your weight _____ (kg)

Please staple Blood Pressure printout here

We usually prescribe 6 packets of the pill. If you prefer fewer packs, please state the number required here: _____

Your signature: _____ Date: _____

Surgery use:

BMI _____ DATA INPUT COMPLETED BY _____ DATE _____

All items to be prescribed generically unless specified.

- ☐ Issue 6m prescription
- ☐ Issue 1m prescription, book appointment for routine review
- ☐ Urgent review
- ☐ COC contraindicated