

Dear Patient,

We are now offering an alternative way to review your contraceptive pill. You are still welcome to book a telephone appointment with a practice nurse for a contraceptive pill review if you would prefer. However, you may wish to fill in our questionnaire below instead.

Please answer ALL the questions on the form and email it to us at reception.harbourside@nhs.net or post it to the surgery. We have a post box on the wall to the left of the main entrance. We will review your symptoms and if necessary ask one of our specialist nurses to call you.

#### For more information on lifestyle advice please visit NHS Choices website [www.nhs.uk/livewell](http://www.nhs.uk/livewell)

**Note:** By using this form you will be sending information about yourself across the internet. We use a secure email service. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantee of absolute privacy. If this matter concerns you then please print off the form, complete it and return to the surgery.

**Personal Information:** Personal information retained on this system is stored in a secure data centre located in the UK and is treated as confidential. The answers that you give will become part of your medical record.

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| **CONTRACEPTIVE PILL REVIEW FORM**All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name  |  |  | Date of birth:  |
| **Home Phone:**  |  | **Mobile phone:** |
| Email address:  |
| Address: |  | Postcode:  |  |
|  |
| Please complete with as much detail as possible |
| Will you be 35 years or older within the next 12 months? | [ ]  Yes |
| [ ]  No |
|  |
| 1. **What is your weight?**
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|  |
| 1. **What is your blood pressure?**

If you do not have a blood pressure monitor please come into the surgery where you can borrow one. |  |
|  |
| 1. **Smoking status**
 | [ ]  Smoker |
| [ ]  Ex-smoker |
| [ ]  Non-smoker |
|  |
| 1. **Have you, or any of your immediate family (mum, dad, brothers or sisters) been diagnosed with any of the following conditions within the past 12 months**
 | [ ]  Deep vein thrombosis (a blood clot in veins of the leg) |
| [ ]  Pulmonary embolism (a blood clot in the lungs)[ ]  Stroke or cerebro-vascular disease[ ]  Heart disease |
|  |
| 1. **Have you been diagnosed with or experienced any of the following conditions in the past 12 months?**
 | [ ]  Unexplained leg swelling |
| [ ]  Chest pain that is worse when breathing deeply or unexplained shortness of breath |
| [ ]  High blood pressure |
| [ ]  High cholesterol |
| [ ]  Diabetes |
| [ ] Liver Disease |
| [ ] Gallbladder disease inc. gallstones |
| [ ] Epilepsy |
| [ ] Raynaud’s disease |
| [ ] Breast cancer |
|  |
| 1. **Are you currently taking any of the following medications?**
 | [ ] Anti-epileptic medication |
| [ ]  Rifampacin |
| [ ] St Johns Wort |
|  |
| 1. **Do you suffer from migraines with aura, or a headache associated with weakness or numbness on one side of your face or body, or difficulty with speech?**
 | [ ]  No | [ ]  Yes |
|  |
| 1. **Have you suffered from any irregular vaginal bleeding, bleeding between periods or bleeding after sex in the past 12 months?**
 | [ ]  No | [ ]  Yes |
|  |
| 1. **Have you forgotten to take your pill on more than one occasion per month?**
 | [ ]  No | [ ]  Yes |
|  |
| 1. **Would you like to discuss 'what to do in the event of a missed pill' with you GP or practice nurse?**
 | [ ]  No | [ ]  Yes |
|  |
| 1. **Would you like to discuss long acting reversible contraception options with you GP or practice nurse?**
 | [ ]  No | [ ]  Yes |