Have you had any irregular bleeding?

Do you suffer from migraines?

BUGBROOKE MEDICAL PRACTICE

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 note, it will take 48 hours to generate your prescription.

PERSONAL DETAILS

Full Name

Mr/Mrs/Miss/Ms/Other

Address and Postcode

Telephone Number

Work Number

Mobile Number

E-mail Address

Date of Birth

Height

Feet/inches

cm

Weight

kg

BMI

Blood Pressure Reading 1 (Please use the machine next to the

Waiting area, 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?

Are you breast feeding?

Yes / No

Do you have a family or personal history of DVT or pulmonary embolism?

Do you smoke?

(please circle 1 box only)

Yes / No

Yes / No

Yes / No

Yes / No

Never Smoked

2-4 times per month

Current Smoker –***Stopping smoking is advised***

Never

Ex-Smoker

Monthly or less

4+ times per week

3-4 drinks

10+ drinks

Less than monthly

Daily or almost daily

How often do you have an alcoholic

drink?

(please tick 1 box only)

2-3 times per

week

1-2 drinks

7-9 drinks

Never

Weekly

How many standard\* alcoholic drinks do

you have on a typical day when you are

drinking?

(please tick 1 box only)

5-6 drinks

How often do you have 6 standard\*

alcoholic drinks on one occasion?

(please tick 1 box only)

Monthly

\* 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:

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:

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Signed: …………………………………

(GP/Nurse)

Date: ……………………………………

Date: