**Chilwell Valley and Meadows Surgery**

**Repeat Prescription request for Combined Oral Contraceptive Pill**

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| --- | --- | --- | --- |
| Name |  | Date |  |
| Name of medication Requested |  | | |
| Is this a repeat medication request? |  | *If you are requesting a new medication please make an appointment to see your GP* | |
| Are you having any side effects? |  | | |
| Do you have migraine or any headaches? |  | *If you have migraines, your GP may need to discuss this further with you* | |
| Do you have or does your family have a history of blood clots e.g. DVT? |  | *If you have blood clots your GP may need to discuss this further with you* | |
| Does your family have a history of breast cancer? |  | *If there is a new diagnosis of breast cancer in your family, your GP will need to discuss this further with you* | |
| Do you smoke?  *If not, are you an ex smoker?* |  | *If you smoke, please state*  *the number of cigarettes per day?* | |
| What is your weight? |  | *A scale is available in the reception area* | |
| What is your height? |  | *A height measuring station is available in reception area* | |
| What is your blood pressure? | / | *Please use the blood pressure machine in the reception area and write down the top and bottom numbers* | |
| When was your last cervical smear test? |  | *If you are over 25y you should have had a cervical smear test. If you have had a smear test, but it was more than 3 years ago please book an appointment for this with the practice nurse* | |

Please Fill out this form and return to the reception

Your doctor may need to contact you about certain details in this form