**Chilwell Valley and Meadows Surgery**

**Repeat Prescription request for Progesterone Only Pill Contraceptive**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 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* |
| 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