**Pill Check: Annual Questionnaire**

This questionnaire is intended for women who wish to continue taking the oral contraceptive pill. If you would like to start taking the pill, completing this questionnaire will help streamline the process, but you will also need to contact the surgery directly to speak to a doctor or nurse.

Please be aware you can request a 12 month supply of your pill as an acute prescription once this questionnaire has been reviewed and the prescription is authorised. You will then need to complete this questionnaire each year before the next 12 month prescription can be issued.

COMBINED PILL (oestrogen and progesterone): For more information on this, including potentially new schedules for taking your pill, please visit the “how to take the pill section” on the page: <https://www.sexwise.org.uk/contraception/combined-pill-coc>

PROGESTERONE ONLY PILL: For more information this please follow this link: <https://www.sexwise.org.uk/contraception/progestogen-only-pill-pop>

If you have any questions about your pill having completed this form please contact the surgery to speak a member of the team.

**Basic Information**

**Full Name**:

**Date of Birth** (dd/mm/yyyy):

**Today’s Date**:

 **Best contact number should we need to contact you**:

**E-mail Address** (optional):

 **Blood Pressure**: Systolic (higher) reading:

 Diastolic (lower) reading:

If you do not have access to a blood pressure cuff at home you can use our waiting room blood pressure monitor (no appointment required). Alternatively please contact our reception team to arrange a check. Several of our local pharmacies may be able to check your blood pressure but you will need to contact them directly to enquire about this.

**Height** (cm):

 **Weight** (kg):

**Are you currently using any other contraception prescribed/ administered by an organisation other than Riverbank Medical Centre (for example by a family planning clinic)?**

**Your Health**

**Do you smoke?**

**If so, on average, how many cigarettes/roll-ups daily?**

**If you have recently given up smoking how long ago did you successfully quit?**

**Have you or anyone in your immediate family (parents, siblings, children) been diagnosed with any of the following problems in the past? If so, please provide details:**

**Deep vein thrombosis** (blood clot in the veins of the leg)?

**Pulmonary embolism** (blood clot in the lungs)?

**A stroke/ mini-stroke?**

**Heart Disease?**

**Breast, ovarian cancer, cervical or womb (endometrial) cancer?**

**Liver or gallbladder disease?**

**Do you suffer from migraines?**

 A migraine is usually a moderate to severe headache felt as a throbbing pain at the front or on one side of the head that can last up to 72 hours. Some people feel sick or vomit, others may feel sensitive to light.

**If yes, do you ever experience an aura with your migraines?**

There can be a sensation/ awareness, or aura, just before the migraine headache starts. This can be **visual**: flashes of light, zig zag lines or blind patches, objects in your vision appearing to move or having difficulty focusing on things. Other people experience changes to skin sensation (typically numbness or pins and needles on one side of their body or face). Others experience speech difficulties. If you are not sure whether your headaches are migraines and/or whether you experience aura please make a telephone appointment to speak to your doctor for advice. For more information see: <https://patient.info/brain-nerves/migraine-leaflet>

**Have you had a baby in the last 6 months?**

**Is there any chance you might currently be pregnant?**

**Have you experienced any bleeding/spotting in between your periods or after having sex in the last 12 months?**

**Have you forgotten to take your pill on more than one occasion in the last 3 months?**

**Would you like to speak to a doctor or nurse about longer acting reversible alternative forms of contraception?**

For example an implant, coil or injections, please see <https://www.sexwise.org.uk/contraception/which-method-contraception-right-me> for more information.

**I confirm that the information I have provided is correct at the time of completing the form. I will inform my GP should there be any changes to my health whilst I am taking oral contraceptive tablets.****[ ]  (tick/cross to confirm)**

**Signature/ Type Name**

**Date**

Copies of this form are also available from our reception team and are available via our website. Please e-mail this completed form to riverbank.documentsin@nhs.net. Alternatively feel free to print it and send it to the surgery via post (Riverbank Medical Centre, Dodsley Lane, Midhurst, West Sussex, GU29 9AW) or deliver it to reception directly.