NHS WESTLANDS MEDICAL CENTRE

Please complete this form and give it to the Dr or Nurse when you have a Combined Contraceptive Pill Review

My name is ☐

I am ☐ years old

I am a smoker? ☐, I am an ex-smoker ☐, I have never smoked ☐

I weigh ☐ Kg and I am ☐ cm tall

(You can measure your height and weight in our exam room, just ask for directions!)

Please answer the following statements yes or no:	**Y**	**N**
I am diabetic	☐	☐
I have hypertension (high blood pressure)	☐	☐
(If so, are you on any medication to treat your high blood pressure)?	☐	☐
I am taking medication to control my cholesterol (eg a statin?)	☐	☐
I have had a Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)?	☐	☐
I have a known blood clotting disorder	☐	☐
I have prolonged mobility problems	☐	☐
I have had major surgery within the last 3 months	☐	☐
I have had an organ transplant	☐	☐
I suffer from migraines with aura	☐	☐
I have been diagnosed with breast cancer/ I am carrier of BRCA1/BRCA2	☐	☐
I have been diagnosed with Heart Disease, Stroke or Atrial Fibrillation	☐	☐
I am currently breast-feeding	☐	☐

If you would like this letter or information in an alternative format, for example large print or easy read, or is you need help communicating with us, for example because you use British Sign Language, please contact the Practice