Shawbirch Medical Practice – Contraceptive Pill Questionnaire

IF YOU ARE UNDER 18 YEARS OLD, PLEASE DO NOT COMPLETE THIS FORM. SPEAK TO RECEPTION FOR ADVICE.

In order to prescribe the contraceptive pill safely, we need to ask you a number of questions. Please complete this form and also have your weight/height/blood pressure checked at the surgery on the machine in the corridor, then hand this form and your results to reception.

We will then review the information you have provided and, if appropriate, will issue a 12-month supply of your pill. If we need to query any of your answers, we will contact you as soon as possible. We may need to book an appointment with a GP or nurse.

If you are having problems with your medication or would like to discuss alternative contraception options, please let us know (question 11).

Todays Date: ....

Name of pill: ....

Patient Details

Name: ....

DOB: .... **IF YOU ARE UNDER 18 YEARS OLD, PLEASE DO NOT COMPLETE THIS FORM. SPEAK TO RECEPTION FOR ADVICE.**

Tel number: ....

Blood pressure: .... / ....

Height: ....cm

Weight: ....kg BMI: .... kg/m2 Pulse: ....

Pharmacy Destination: ....

Please answer the following questions.

1. Are you a smoker? **Y / N**

   If yes to the above, would you like help giving up? **Y / N**

Continued overleaf >

2. Are you aware:

   a) How the pill works? **Y / N**

   b) What to do if you miss a pill? **Y / N**

   c) That the contraceptive pill may not work if you have vomiting and/or diarrhoea? **Y / N**

   d) That the contraceptive pill does NOT protect you from sexually transmitted infections, so you need to use a condom as well to protect yourself? **Y / N**

   e) Of the alternatives such as long acting reversible contraception? **Y / N**

3. Do you suffer from migraines? **Y / N**

   If yes to the above, do you experience visual symptoms or changes in sensation or muscle power on one side of your body? **Y / N**

4. Do you have parents or siblings who have had heart disease or strokes under the age of 45? **Y / N**

5. Do you have diabetes? **Y / N**

6. Have you had deep vein thrombosis or pulmonary embolus? **Y / N**

7. Do you have parents or siblings who have had deep vein thrombosis or pulmonary embolus under the age of 45? **Y / N**

8. Do you have any blood clotting illnesses or abnormalities? **Y / N**

9. Do you have any family history (mother and sister) of breast cancer under the age of 50? **Y / N**

10. Have you had any bleeding between your periods or after having sexual intercourse? **Y / N**

11. Would you like to book a consultation with a GP to discuss or arrange a fitting of a long term reversible contraception? **Y / N**

Thank you for completing this form. If there are any problems with issuing your prescription, we will contact you via telephone, so please make sure you have provided a contact number on the front page.

CLINICIAN ACTION:

UK MEC Criteria to be reviewed:
CATEGORY 1 – no restriction to use of method
CATEGORY 2 – benefits of method outweigh the risks
CATEGORY 3 – risks outweigh the advantages of the method
CATEGORY 4 – method has unacceptable health risk/s