ORAL CONTRACEPTIVE REPEAT REQUEST FORM 

WALFORD MILL MEDICAL CENTRE

Please use this form to request your regular repeat contraceptive pill. Thank you for your help in saving our nursing appointments!

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| --- | --- | --- | --- |
| Your details | | | |
| Full name |  | | |
| Mobile telephone |  | Date of birth |  |
| Current address |  | | |

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| --- | --- | --- | --- |
| Your contraceptive pill | | | |
| Which pill are you currently taking? |  | | |
| For how long have you been taking this pill? | * Less than 3 months * 3-12 months * A year or more | | |
| Have you had this pill from us before? | * Yes * No | | |
| Would you like to use EPS (electronic prescribing direct to a pharmacy of your choice? | * Yes * No | Chosen pharmacy: |  |

|  |  |  |
| --- | --- | --- |
| Your medical history | | |
| Have you ever had any problems with your current pill or are you unhappy with it? | YES | NO |
| Have you ever had any kind of migraine? (***Medically this refers to a severe throbbing headache, often on one side of the head which can be associated with flashing lights, sickness or with a dislike of noise or light***) | YES | NO |
| Have you ever had any episodes of deep vein thrombosis (DVT) or blood clot in your lung? (***Medically this refers to any blood clot in your leg, or any requirement for blood thinning medication such as warfarin or similar***) | YES | NO |
| Have any of your family had a DVT (blood clot) in their legs or lungs?  If so, please tell us which relative : | YES | NO |
| Do you have any family history of breast cancer?  If so, please tell us which relative and at what age they were diagnosed.  Relative: Age:  Relative: Age: | YES | NO |
| Have you ever had any problems with your liver? | YES | NO |
| Have you developed any new medical problems since you last saw us? If so, what? | YES | NO |
| Are you taking St John’s Wort? (***a herbal anti-depressant***) or any other regular medications we are not aware of ***(this is important as some ‘over the counter’ medications can make your contraception less effective)*** | YES | NO |

|  |  |  |
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| Your information | | |
| Do you smoke? | * Never smoked * Ex-smoker. When did you stop? * Current smoker. How many per day | |
| Please provide the following: | Height (cm) : | Weight (kg) : |
|  | Blood pressure:  **(If you do not have access to your own monitor please ask at a local pharmacy / or Walford Mill reception)** | / mmHg |
|  | If your reading is above 140 systolic or above 90 diastolic please repeat two more times | 1. / mmHg |
| 2. / mmHg |
| Please remember there are other forms of contraception available such as ‘long acting reversible contraceptives’(LARCS). These include the contraceptive implant. If you would like more information on these methods please book an appointment with us, or have a look at patient.co.uk | | |

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| Your declaration |
| The information I have supplied on this form is true and complete to the best of my knowledge.  Signature: Date: |

***Please now return this form to reception for processing***

***Please allow up to FIVE WORKING DAYS for your prescription to be processed.***

|  |  |  |  |
| --- | --- | --- | --- |
| ***For surgery use only*** | Date received   * Scanned | * Script issued * Needs telcon * Needs F2F | Clinician Initials |