**The Hall Practice**

**CALCOT MEDICAL CENTRE**

**Questionnaire for Repeat Prescription of the Oral Contraceptive Pill**

|  |  |
| --- | --- |
| **Completion date** | Completion date |
| **Name** | Name | **Age** | 00 |
| **What is your current contraceptive pill?** | Name of pill |
| **Have you been on this pill longer than 9 months?** | Select your answer |
| **Are you experiencing any unwanted side effects?** | Select your answer |
| **Is your bleeding pattern regular?** | Select your answer |
| **Do you get any bleeding in between your periods or after sex?** | Select your answer |
| **Have there been any new cases of breast cancer or blood clots in your family since your last prescription?** | Select your answer |
| **Do you suffer from migraines?** | Select your answer |
| **Do you smoke?** | Select your answer | **Cigarettes per day** | 00 |
| **What is your current weight in kilograms?** | 000.0 |
| **What is your current blood pressure (see below)?** | 000/000 |
| **Collection point for prescription** | Select your answer | Other location |

Thank you for filling in this questionnaire. Please ensure you include a current blood pressure reading on this form and we will be able to process your request for a prescription in the next 2 working days.

If you do not have a blood pressure monitor at home you can pop into the surgery waiting room at anytime during opening hours (M-F 07.30-18.00) and use the self-check machine.

**PLEASE SAVE YOUR COMPLETED FORM AND EMAIL TO: thehallpractice.frontdesk@nhs.net**