**Rolle Medical Partnership**

**Contraceptive Pill Request Form**

*Please hand this questionnaire to reception with a weight and blood pressure reading taken within the last year. We may still need to book you an appointment with the nurse if the readings are outside certain limits.*

**For your safety, we need to make sure you are aware of the following:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| * How the pill works? | 🗆 | 🗆 |
| * Side effects and Risks of taking the pill? | 🗆 | 🗆 |
| * You should not smoke when taking the pill as this increases your risks of having a stroke? | 🗆 | 🗆 |
| * What to do if you miss a pill? | 🗆 | 🗆 |
| * The pill may not work if you vomit within 2 hours of taking the pill or have severe diarrhoea. | 🗆 | 🗆 |
| * That the contraceptive pill does NOT protect you from sexually transmitted infections, so you will need to use a condom as well to protect yourself. | 🗆 | 🗆 |

For more information on Risks and Drug interactions and Side Effects of taking the pill you can download the pill leaflet from [www.fpa.org.uk](http://www.fpa.org.uk)

*If the answer to any of the above questions in* ***NO*** *please make an appointment with the Practice Nurse.*

**Medical History. Do you have:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| * Any problems with using your contraceptive pill or side effects from the pill | 🗆 | 🗆 |
| * Any health matters you wish to discuss with your GP or Practice Nurse | 🗆 | 🗆 |
| * Migraine headaches, severe headaches or frequent headaches | 🗆 | 🗆 |
| * Bleeding between periods | 🗆 | 🗆 |
| * Bleeding during or after sexual intercourse | 🗆 | 🗆 |
| * Unusual discharge | 🗆 | 🗆 |
| * History or thrombosis (blood clots in veins or lungs) or family history of clots | 🗆 | 🗆 |
| * Do you have a family history of breast cancer | 🗆 | 🗆 |

*If the answer to any of the questions is* ***YES*** *please make an appointment with the Practice Nurse.*

**Smoking Status:**

Never smoked 🗆

Stopped smoking 🗆 Date Stopped

Cigarette smoker 🗆 Number of cigarettes smoked per day…………….

**Please enter the following:**

Name: …………………………………………………………………. DOB: .…………………………..…….

Address: ……………………………………………………………………………………………………………….……….…

Contact Number: ……………………………………………………………………………………………………….…….

Blood Pressure Reading (there is a BP machine in the waiting room): ………...../……..……...

Height: ………………………………. Weight: ……………………………….

Date of last smear if 25 or over: ………………………………………………………………………………………

Medication Required: ……………………………………………………………………………………………………...

Signature: ………………………………………………………….. Date: …………………………………..

We recommend the website [www.fpa.org.uk](http://www.fpa.org.uk) for information on the Pill and alternatives such as Long Acting Contraceptives. Please remember that the Pill does not protect against Sexually Transmitted Infections.

Sexual health screening is provided at the Walk in Centre on Sidwell Street, Exeter. Tel: 01395 276892 or Family Planning Clinic Dewdney Unit Exmouth open every Thursday 1-3pm & 4-7pm Tel: 01392 284892/3 to make an appointment. Self screening swabs for chlamydia are available at reception or from the Practice Nurse.