Evidence B – Amended Contraceptive Pill Checklist

Part of New Horizons Medical Partnership

Contraceptive Pill Checklist

For women 18 years and older

In order to provide the contraceptive pill safely we need to ask you a number of questions. We would be grateful if you could complete this form when you submit your next repeat prescription request.

If you are having any problems with your medication or would like to consider alternative contraception options, please speak to one of our Practice nurses, who will be able to advise you, or refer you to the Doctor as appropriate.

Patients Name: ……..

Date of Birth: ……. **Date:……..**

Contact Number:……(That you are happy for us to contact you on, to leave a message or to send a text, if there are any queries)

HEIGHT	**WEIGHT**	**BLOOD PRESSURE**
…….	……..	……

Name of Pill requested ……

Are you currently happy with this method of contraception? ☐Yes ☐No

Please be aware that the contraceptive pill does not protect you from sexually transmitted infections. You need to use a condom to protect yourself.

Please measure your blood pressure using the BP machine at the main surgery waiting room and attach it to this form

1. Are you a smoker/vape/e-cigarette ☐Yes ☐No
   Or when did you stop …….
2. Would you like help giving up? ☐Yes ☐No
   (If you smoke whilst using a hormonal contraceptive the risk of cardiovascular disease is increased, this means you are more likely to have a heart attack or stroke)
3. Are you aware:
   a) How the pill works? ☐Yes ☐No
   b) What to do if you miss a pill? ☐Yes ☐No

c) Have you missed any pills in the last 3 months ☐Yes ☐No ☐ How Many ……

d) That the contraception may not work if you have diarrhoea or vomiting. ☐Yes ☐No

4. Do you suffer from migraines? ☐Yes ☐No
   If so, do you suffer from visual symptoms or changes in sensation or muscle power on one side of your body? ☐Yes ☐No
   (If you start having migraines after starting a new contraceptive or develop migraines at any point please let the GP surgery know)
5. Do you have parents or siblings who have had heart disease or stroke ☐Yes ☐No
6. Have you or any family member had a deep vein thrombosis or Pulmonary Embolus (blood clot in the leg or lung) ? ☐Yes ☐No
7. Do you have blood clotting illnesses/ abnormalities? ☐Yes ☐No
8. Do you have any family history of breast cancer under the age of 50? ☐Yes ☐No
9. Are you taking any of the following medications?
   Herbal remedies e.g. St Johns Wart ☐Yes ☐No
   Liver enzyme inducing drugs e.g. Rifabutin, Rifampicin, Carbamazepine, Phenytoin ☐Yes ☐No
   (if unsure please contact surgery)
10. Are you aware of the alternatives such as long acting reversible contraceptive (please read the attached pages) ☐Yes ☐No
11. Would you like to book a consultation with a doctor to discuss long acting reversible contraceptive ☐Yes ☐No or arrange fitting a
12. Have you had any abnormal bleeding or bleeding after intercourse? ☐Yes ☐No

Additional information:

- Please remember cervical screening (smear) testing – every 3 years for women age 25-50 and every 5 years for women ages 50-65.
- Please ensure that you are familiar with the following information regarding breast examination, if you require this in a different format or would like an explanation/verbal information please contact the surgery – www.nhs.uk – How should I check my breasts?
- Please be aware that the combined oral contraceptive pill has a small risk of causing a blood clot, if you are concerns about any red, hot or tender swelling to the legs or any sudden shortness of breath please seek the appropriate service 999 in emergency.

Thank you for completing this form. Please return it with your BP reading.
If we have any problems with re-issuing your prescription we will contact you. If not, your prescription will be ready for you to collect within 5 working days. Long- acting Reversible Contraceptive (LARC)

I confirm the above information is accurate and up to date.

Signed: …….. Date: ……..