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**Contraceptive Pill Checklist for Repeat Prescription**

***(For patients between the age of 16 and 45)***

We are improving how patients can order repeat prescriptions for contraceptive pills. Please answer the questions below, and if there are no problems, we will issue a prescription for six months within 3 working days.

Please answer the questions accurately to ensure we can provide the contraceptive pill safely.

1. Your name: **………………………………………**
2. Your Date of Birth: **………………………………………**
3. Today’s Date: **………………………………………**
4. Contact number (for any query): **………………………………………**
5. When do you need your contraception by? **………………………………………**
6. Which pill are you taking? **………………………………………**
7. Do you smoke? [ ] Pipe [ ] Cigarettes [ ] Cigars [ ] No. If yes, how many: **….….….**
8. What is your weight? **………………………………………**
9. What is your blood pressure? **……………………/…………………**
10. Since your last prescription have you:

Experienced any problem with your pill? [ ] Yes [ ] No

Suffered from a blood clot or thrombosis? [ ] Yes [ ] No

Developed migraine? [ ] Yes [ ] No

Been diagnosed with diabetes? [ ] Yes [ ] No

Been diagnosed with hypertension (raised blood pressure)? [ ] Yes [ ] No

Been diagnosed with cancer? [ ] Yes [ ] No

Had any unexpected vaginal bleeding between periods or after sex? [ ] Yes [ ] No

***If you answered ‘yes’ to any of these, please make an appointment.***

11) To which chemist should we send the prescription? **……………………………………**

For admin use:

Date of last Cervical Smear: **……/……/……** BMI: **………………**

NB If age >35 and smoker will need review

Checked by: …………………………………………. Date: ……/……/……….