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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: ……/……/……….