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Questionnaire for Patients on Contraceptive Pill

Name: _____ Date of birth: _____ Age: _____

1. Personal Medical History: Has anything changed, in particular, do you have, or have you ever had (please tick):

	Yes	No		Yes	No	**Other/comments:**
Migraine			High Blood Pressure			
DVT (Blood clot in the leg)			Epilepsy			
PE (Blood clot in the lung)			Heart Disease			
Breast Cancer			Stroke			
Irregular periods			Vaginal bleeding after sex			

2. Family History: Has anything changed in your family history? In particular (please tick):

	Yes	No		Yes	No	**Other/comments:**
Breast Cancer			High Blood Pressure			
DVT (Blood clot in the leg)			Factor V Leiden			
PE (Blood clot in the lung)			Heart Disease			
Blood clotting problems			Stroke			

3. Lifestyle, please tick:

	Yes	No	
Do you smoke?			If yes, how many a day? _____ What year did you start? ____
Do you drink alcohol?			If yes, how many units a week? _____

4. Examination. You can measure your blood pressure, height and weight using our self-assessment room. Alternatively, make an appointment with our healthcare assistants (HCAs)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

5. Disclaimer: I agree that all the information above is correct. Sign: _____ Date: _____

What happens now? The form will be given to a GP who will check it & issue your medication

Are you aware that you can get emergency contraception from local pharmacies and Locala? For all your sexual health requirements, including a free chlamydia screen, please contact Locala (0303 330 9500, https://www.locala.org.uk/services/sexual-health/sexual-health-clinic-times/)

FOR OFFICE USE ONLY:

Handed out LARC information sheet ☐ Details added to screen ☐ Copy given to scanning ☐