**Contraception Pill Check**

**Please email this questionnaire to D-CCG.Stleonardspractice@nhs.net**

This questionnaire will enable us to provide you with a prescription for the Pill in a timely manner.

**Name: Date:**

**DOB:**

**Height: Weight:**

**Blood pressure today (if possible):** /

**Smoking status:**

* Never smoked
* Stopped smoking Date stopped …..
* Cigarette smoker Number of cigarettes smoked per day …..

If you need advice on how to stop smoking please speak to our reception staff to make an appointment

**Any problems with the Pill:**

**Yes** **No**

|  |  |  |  |
| --- | --- | --- | --- |
| Recent change in headaches |  |  |  |
|  |  |  |  |
| Bleeding in between periods |  |  |  |
|  |  |  |  |
| Bleeding after sex |  |  |  |
|  |  |  |  |
| Unusual vaginal discharge |  |  |  |
|  |  |  |  |

Other (please describe) ………………………………………………………

If you have answered yes to any of the above please make an appointment to see your doctor

Please use [www.patient.co.uk](http://www.patient.co.uk) for information on the Pill and Long Acting Reversible Contraceptives

The Pill does not protect against Sexually Transmitted Infections. Many couples use condoms as well as the Pill to protect against these.

Sexual health screening is provided at the Walk in Centre on Sidwell Street. Tel: 01392 28498

**For admin use only: please tick and date once actioned and pass on for further actioning**

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| **(1)SCANNING** |  | **(2) DATA Q** |  | **(3)SCRIPTS** |  |