CONTRACEPTION REPEAT REQUEST FORM

NHS
University Health Service

YOUR DETAILS			
Full name			
Mobile telephone		Date of birth	
Current address			

YOUR PILL			
Which pill are you currently taking?			
For how long have you been taking this pill?	☐ Less than 3 months ☐ 3-12 months ☐ A year or more		
Have you had this pill from us before ***(if "No" you will need to see a GP or Nurse Practitioner first)***	☐ Yes ☐ No	Happy to use EPS? ***(electronic prescribing direct to Pharmacy)***	☐ Yes ☐ No
		Preferred Pharmacy	

YOUR MEDICAL HISTORY	YES	NO
Have you had any problems with your current pill or are you unhappy with it?	☐	☐
Have you ever had any kind of migraine? *(By migraine we mean a severe headache often with a dislike of noise or light, visual disturbances such as flashing lights or blank spots in your vision, or sickness).*	☐	☐
Have you ever had any episodes of deep venous thrombosis (DVT) or blood clot in your lung? *(By this we mean a blood clot in your leg or requiring blood thinning medication such as warfarin or rivaroxaban)*	☐	☐
Have any of your close family had a DVT (blood clot) to their legs or lungs?	☐	☐
Have any of your close family had a heart attack or stroke age less than 45 years?	☐	☐
Have you got any family history of breast cancer? If so, please tell us which relative (e.g. mother sister etc) and what age they developed cancer. Relative: Age: Relative: Age:	☐	☐
Have you ever had any problems with your liver?	☐	☐
Have there been any changes to your medical health since you were last seen? If so, what?	☐	☐
Are you taking St John's Wort *(a herbal anti-depressant)* or Modafanil (a 'study drug' to improve wakefulness) or any other medication that we are not aware of? If so, what? **Some medications make your contraception less effective during and for a period of time after taking**.	☐	☐

YOUR OBSERVATIONS			
Do you smoke?: ☉ Never smoked ☐ Ex-smoker When did you stop? _____ ☐ Current smoker How many? _____ per day	Please complete the readings from the health monitor:		
	Height: cm	Weight:	kg
	Blood pressure:	/	mmHg
	If your readings are **above 140** systolic or **above 90** diastolic, please repeat two more times	Repeat #1: /	mmHg
		Repeat #2: /	mmHg

If you haven't had a chlamydia test within the last year or if you're with a new partner we recommend being tested. Please see www.letstalkaboutit.nhs.uk to order a kit online.

Please remember that there are lots of difference contraceptives available from pills, injections, implants and coils, if you wish to discuss these please make an appointment or look at the website http://www.unidocs.co.uk/cash-contraception-guides.php

DECLARATION

The information I have supplied on this form is to the best of my knowledge true & complete.

Signed: Date:

Once complete, please return to reception for processing.

Your prescription will be ready TWO WORKING DAYS after submission, unless you hear from us.

For office use only	Date received: ☐ Scanned Passed to:	☐ Prescription issued ☐ Pls book tel appt ☐ Pls book 1:1 appt	Dr Initials: