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| NAME |  |
| DOB |  |
| TELEPHONE NUMBER |  |
| WHAT IS THE NAME OF YOUR CONTRACEPTIVE PILL? | |
| HOW DO YOU TAKE YOUR CONTRACEPTIVE PILL?  EVERY DAY (MINI PILL)……… OR FOR 21 DAYS WITH A 7 DAY BREAK (COMBINED PILL)? | |
| WHICH PHARMACY DO YOU COLLECT YOUR PRESCRIPTION FROM? | |
| PLEASE RECORD YOUR BLOOD PRESSURE ……………………………………..  BLOOD PRESSURE MONITORS ARE READILY AVAILABLE TO PURCHASE FROM PHARMACIES AND GIVE ACCUATE READINGS | |
| PLEASE RECORD YOUR WEIGHT (KG) | |
| PLEASE RECORD HEIGHT IN (CM) | |
| **YES NO** | |
| DO YOU SMOKE? ………. IF YES HOW MANY DO YOU SMOKE A DAY? ………… | |
| HAVE YOUR PARENTS OR SIBLINGS HAD HEART DISEASE OR A STROKE UNDER THE AGE  OF 45 | |
| HAVE YOU HAD A DEEP VEIN THROMBOSIS (DVT) OR PULMONARY EMBOLUS? | |
| DO YOU HAVE ANY BLOOD CLOTTING ILLNESS OR ABNORMALITIES? | |
| DO YOU SUFFER FROM MIGRAINES? IF YES :  IN THE 30-60 MINUTES BEFORE YOUR MIGRAINE STARTS DO YOU GET SYMPTOMS TO  WARN YOU THAT A MIGRAINE IS COMING?  DO YOU EXPERIENCE VISUAL SYMPTOMS OR CHANGES IN SENSATION OR MUSCLE POWER  ON ONE SIDE OF YOUR BODY? | |
| DO YOU DIABETES? | |
| DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER UNDER THE AGE OF 50? | |
| DO YOU KNOW HOW THE PILL WORKS? | |
| DO YOU KNOW WHAT TO DO IF YOU MISS A PILL? | |
| DO YOU KNOW THAT THE PILL MAY NOT WORK IF YOU HAVE DIARRHOEA OR VOMITING? | |
| DO YOU KNOW THAT THE PILL WILL NOT PROTECT YOU FROM SEXUALLY TRANSMITTED  INFECTIONS, SO YOU WILL NEED TO USE A CONDOM AS WELL FOR PROTECTION? | |
| DO YOU UNDERSTAND THAT YOU SHOULD TELL A HEALTHCARE PROFESSIONAL  THAT YOU ARE ON THE PILL IF YOU NEED TO HAVE AN OPERATION OR HAVE A PERIOD  OF PROLONGED IMMOBILISATION, E.G. LEG IN PLASTER > | |
| DO YOU KNOW THAT THE RISK OF A CLOT WITH THE COMBINED PILL  INCREASES IF YOU TRAVEL FOR EXTENDED PERIODS? E.G LONG-HAUL FLIGHTS | |
| ARE YOU AWARE OF THE ALTERNATIVE SUCH AS LONG-ACTING REVERSIBLE  CONTRACEPTION IMPLANTS, INJECTIONS AND INTRA-UTERINE DEVICES (COIL)? | |
| DO YOU UNDERSTAND THE SYMPTOMS OF A BLOOD CLOT ARE CALF PAIN AND  SWELLING, SHARP CHEST PAIN, SHORTNESS OF BREATH OR COUGHING UP BLOOD | |
| WOULD YOU BE HAPPY TO CONTINUE USING A CHECKLIST FOR YOUR PILL CHECK  IN FUTURE? | |

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| PRACTICE USE ONLY | | | | | |
| CHECKED BY | | NAME | | DATE | |
| PRESCRIPTION ISSUED | 3 MONTHS | | 6 MONTHS | | 12 MONTHS |
| FOLLOW-UP | CHECKLIST ONLY | | PHONE CALL | | FACE TO FACE |