ORAL CONTRACEPTIVE REPEAT REQUEST FORM
WALFORD MILL MEDICAL CENTRE

Please use this form to request your regular repeat contraceptive pill. Thank you for your help in saving our nursing appointments!

Your details			
Full name			
Mobile telephone		Date of birth	
Current address			

Your contraceptive 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?	☐ Yes ☐ No		
Would you like to use EPS (electronic prescribing direct to a pharmacy of your choice?	☐ Yes ☐ No	Chosen pharmacy:	

Your medical history		
Have you ever had any problems with your current pill or are you unhappy with it?	YES ☐	NO ☐
Have you ever had any kind of migraine? (***Medically this refers to a severe throbbing headache, often on one side of the head which can be associated with flashing lights, sickness or with a dislike of noise or light***)	YES ☐	NO ☐
Have you ever had any episodes of deep vein thrombosis (DVT) or blood clot in your lung? (***Medically this refers to any blood clot in your leg, or any requirement for blood thinning medication such as warfarin or similar***)	YES ☐	NO ☐
Have any of your family had a DVT (blood clot) in their legs or lungs? If so, please tell us which relative :	YES ☐	NO ☐
Do you have any family history of breast cancer? If so, please tell us which relative and at what age they were diagnosed. Relative: Age: Relative: Age:	YES ☐	NO ☐
Have you ever had any problems with your liver?	YES ☐	NO ☐
Have you developed any new medical problems since you last saw us? If so, what?	YES ☐	NO ☐
Are you taking St John's Wort? (***a herbal anti-depressant***) or any other regular medications we are not aware of ***(this is important as some 'over the counter' medications can make your contraception less effective)***	YES ☐	NO ☐

Your information		
Do you smoke?	☐ Never smoked ☐ Ex-smoker. When did you stop? ☐ Current smoker. How many per day	
Please provide the following:	Height (cm) :	Weight (kg) :
	Blood pressure: **(If you do not have access to your own monitor please ask at a local pharmacy / or Walford Mill reception)**	/ mmHg
	If your reading is above 140 systolic or above 90 diastolic please repeat two more times	1. / mmHg 2. / mmHg
Please remember there are other forms of contraception available such as 'long acting reversible contraceptives'(LARCS). These include the contraceptive implant. If you would like more information on these methods please book an appointment with us, or have a look at patient.co.uk		

Your declaration	
The information I have supplied on this form is true and complete to the best of my knowledge.	
Signature:	Date:

Please now return this form to reception for processing
Please allow up to FIVE WORKING DAYS for your prescription to be processed.

For surgery use only	Date received ☐ Scanned	☐ Script issued ☐ Needs telcon ☐ Needs F2F	Clinician Initials