

**University Health Service
Contraception repeat request form**

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?	<input type="checkbox"/> Less than 3 months <input type="checkbox"/> 3-12 months <input type="checkbox"/> A year or more		
Have you had this pill from us before <i>(if "No" you will need to see a GP or Nurse Practitioner first)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Happy to use EPS? <i>(electronic prescribing direct to Pharmacy)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Preferred Pharmacy	

YOUR MEDICAL HISTORY		
Have you had any problems with your current pill or are you unhappy with it?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever had any kind of migraine? <i>(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).</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever had any episodes of deep venous thrombosis (DVT) or blood clot in your lung? <i>(By this we mean a blood clot in your leg or requiring blood thinning medication such as warfarin or rivaroxaban)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have any of your close family had a DVT (blood clot) to their legs or lungs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have any of your close family had a heart attack or stroke age less than 45 years?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever had any problems with your liver?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have there been any changes to your medical health since you were last seen? If so, what?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you taking St John's Wort <i>(a herbal anti-depressant)</i> or any other medication that we are not aware of? If so, what?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

YOUR OBSERVATIONS			
Do you smoke?: <input type="checkbox"/> Never smoked <input type="checkbox"/> Ex-smoker When did you stop? _____ <input type="checkbox"/> Current smoker How many? _____ per day	Please complete the readings from the health monitor:		
	Height: _____	cm	Weight: _____
	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:	<input type="checkbox"/> Prescription issued <input type="checkbox"/> Pls book tel appt <input type="checkbox"/> Pls book 1:1 appt	Dr Initials: _____
	<input type="checkbox"/> Scanned		
	Passed to: _____		