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| **Repeat Contraception Request Form** |
| **Please complete and hand this into reception or access on the website under family health section and email it to burnbrae.medicalpractice@nhs.net** |  | Date | Time |  |

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| *Please answer all the questions.**You can attend the Pharmacy for a Blood Pressure and Weight check* |

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| Name: | Date of birth: Age: |
| Email |  |
| **ARE YOU UP TO DATE WITH SMEAR?** \*\*\*\*IF NOT SEE PRACTICE NURSE.\*\*\*\* | Mobile number: |
| Name of contraception: | Length of time on this method: |
| Any late or missed pills? |  |
| If yes, what date and how many days missed? |  |
| Date of your last period: |  |
| Have you been checked for sexually transmitted infections recently? |  |
| Would you like a sexual health check? |  |
| Do you smoke? If so, how many a day? |  |
| Do you have any bleeding you consider to be abnormal with this method? If yes please explain: |  |
| Do you have any bleeding after sex? |  |
| Have you ever had headaches, particularly where you have a sense of visual changes, numbness, or tingling before the headache? |  |
| Do you have any breast disease in your family, or have you had breast disease (including cancer)? Give details. |  |
| Have you or anyone in your family ever had a blood clot (stroke or DVT)? |  |
| Any new problems with this method. Any changes since your last check? |  |
| Are there any other health problems you would like to talk about? |  |
| Have you recently had a baby (last 6 months)? |  |
| Are you breastfeeding? |  |
| **\*\*\*\*\*\*\*What is your current weight? \*\*\*\*\*\*\*** |  |
| **\*\*\*\*\*\*\*What is your current blood pressure (please give date of reading) \*\*\*\*\*\*\*** |  |