Contraceptive Pill Review Questionnaire:

For Oral Combined Contraceptive Pill

Questions

**1. Do you know the name of the contraceptive pill that you want?**

* Yes
* No
* No, but I want the same one that I was given last time

**2. What is the name of the contraceptive pill you are requesting a repeat prescription for?**

**3. Have you started taking any new regular medications or health supplements (e.g. St John’s Wort) recently?**

* Yes
* No

**4. What are the names of the new regular medications or health supplements (e.g. St John’s Wort) that you have started taking since your last prescription?**

**5. Have you been diagnosed with any new health conditions since we last issued you a prescription for the pill? These could be any conditions but in particular: heart disease, stroke, breast cancer, liver disease.**

* Yes
* No

**6. What new health conditions have you been diagnosed with since your last prescription?**

To ensure prescribing the pill is safe, please answer the following questions about medical issues that you may have or that run in your family.

**7. Are you getting new or worsening headaches?**

* Yes
* No

**8. Do you get migraines?**

(A migraine is usually a moderate or severe headache felt as a throbbing pain on one side of the head.

* Yes
* No
* I don't know

(If I don't know)

**9. Please describe your headaches**

* Free text field

**10. Do you have an aura with your migraines?**

(An aura is where you have warning signs before your headache begins such as changes to your vision or numbness/pins and needles.)

* Yes
* No
* I don't know

**11. Have you ever had a blood clot (also known as DVT/PEs)?**

**These are clots that cause swollen and painful arms, legs or chest pain.**

* Yes
* No

**12. Have any of your immediate family ever had a blood clot (DVT/PE)?**

(Your immediate family includes your father, mother, brother and sister)

* Yes
* No
* I don't know

**13. Have any of your immediate family or second-degree relatives ever had breast cancer?**

(Your immediate family include your father, mother, brother or sister. Your second-degree relatives include your aunts, uncles, nephews, nieces, grandparents and grandchildren)

* Yes
* No
* I don't know

**14. Which relatives had breast cancer? Approximately, what age were they diagnosed with it?**

**15. Do you have any new unexpected bleeding between your periods since your last review?**

* Yes
* No

**16. Do you have any new bleeding after sex since your last review?**

* Yes
* No

**17. Are you up-to-date with your cervical screening (smear test)?**

* Yes
* No

**18. Are you interested in having any sexual health screening?**

(This could be important as the oral contraceptive does not protect against sexually transmitted infections)

* Yes
* No

**19. What is your smoking status?**

* Current smoker
* Ex-smoker
* Never smoked

**20. How much do you smoke?**

* < 1 cigarette or equivalent per day
* 1-9 cigarettes or equivalent per day
* 10-19 cigarettes or equivalent per day
* 20-39 cigarettes or equivalent per day
* 40+ cigarettes or equivalent per day

**21. Are you able to provide a blood pressure reading?**

**To safely prescribe the contraceptive pill, it is important that we have an up-to-date blood pressure reading.**

* Yes
* No

**Before you take your blood pressure reading:**

* Sit down comfortably for 5 minutes.
* Wear loose-fitting clothing.
* Make sure your arm is around the same level as your heart.
* Make sure your arm is relaxed.

**When taking your blood pressure:**

* Put the cuff on following the instructions which came with your blood pressure monitor.
* Keep still and silent.

**Other tips:**

* Take at least three readings, each two minutes apart.
* Your first reading may be much higher than the next readings. If this is the case, keep taking readings until they level out and stop falling. Use this as your reading.

**Please seek urgent medical attention if you develop any of the following:**

* **Blood pressure is 180/110 or above (despite repeating it at least 2 times)**
* **Chest pain**
* **Changes in vision**
* **Confusion**
* **Severe headache**

**22. Please enter your systolic (SYS) blood pressure reading. This is the top reading.**

**23. Please enter your diastolic (DIA) blood pressure reading. This is the lower reading.**

**Note: This is NOT the pulse.**

**24. Do you know your weight?**

* Yes
* No

**25. Please enter your weight in kilograms.**

**26. Do you know your height?**

* Yes
* No

**27. Please enter your height in metres.**

**28. Are you having any side effects or problems from your contraceptive pill that you would like to discuss with your GP/nurse?**

* Yes
* No

**29. Is there anything else regarding the contraceptive pill that you would like us to know?**