**PLEASE COMPLETE ALL QUESTIONS**

**INCOMPLETE FORMS WILL NOT BE PROCESSED**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name |  | Date of birth |  |
| Contact number |  | Consent to SMS | YES/NO |
| **Do you require a prescription for the contraceptive pill or patch?** | | | YES/NO |
| If yes, name of contraceptive required: | | | |
| **How long have you got left of your current prescription:**  We recommend you make this request when you start your last packet from your previous prescription, more urgent requests should also be completed on this form but we cannot guarantee a quick turnaround. | | | |
| Are you aware of long acting contraception?  For example Implants and coils. Please see [**www.sexwise.fpa.org.uk**](http://www.sexwise.fpa.org.uk)for more information or speak to a GP. | | | |

**Please take two blood pressure readings at least 5 minutes apart (mandatory information):**

|  |  |  |
| --- | --- | --- |
| Date | | BP Reading (e.g. 120/80) |
| 1. |  |  |
| 2. |  |  |

**Please provide your current height and weight (mandatory information):**

|  |  |  |  |
| --- | --- | --- | --- |
| Weight | **kg** | Height | **cm** |

**Please record your smoking status (mandatory information):**

|  |  |  |  |
| --- | --- | --- | --- |
| Never smoked |  | Ex-smoker |  |
| Smoker |  | What + how much? |  |

If you are interested in support to help you to stop smoking please contact the Smokestop Service: [www.livewelldorset.co.uk](http://www.livewelldorset.co.uk) or call 0800 840 1628

**General Health Questions (mandatory information):**

|  |  |
| --- | --- |
| Any previous problems with your contraceptive pill or patch? If yes, please explain | |
| Do you have regular headaches? | **YES/NO** |
| If yes, how often per month? |  |
| Do you think they are migraines? | **YES/NO** |
| Are you having any problems missing pills? | **YES/NO** |
| If yes, how many? |  |
| Has there been anyone in your family with a history of blood clot or deep vein thrombosis? | **YES/NO** |
| Do you have problems with periods such as:  Too heavy? **YES/NO**  Bleeding between periods? **YES/NO** | |
| Bleeding after intercourse? **YES/NO** | |
| Any comments? | |