Central and North West London NHS
NHS Foundation Trust

Pill
Resupply Clinic
Questionnaire for progestogen only pill

Name ..... **Date of Birth** .....

1. Have you taken any of your pills late or missed any pills in the last 3 months? ☐ Yes ☐ No

2. Since your last visit to our clinics have you had or do you currently have any of the following conditions:

- High blood pressure ☐ Yes ☐ No
- Thrombosis (blood clots in legs or in the lungs) ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Heart disease ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- High cholesterol ☐ Yes ☐ No
- Liver disease or Jaundice or Gall stones ☐ Yes ☐ No

3. Since your last visit here have you had any of the following:

- Pregnancy ☐ Yes ☐ No
- Breast problems ☐ Yes ☐ No
- Any serious illness ☐ Yes ☐ No
- Any major surgery ☐ Yes ☐ No

4. Changes in bleeding patterns with progestogen-only pill use are common. Are you worried about your bleeding pattern and do you wish to discuss this with the clinician? ☐ Yes ☐ No

5. Do you have any known allergic reaction to medicines? ☐ Yes ☐ No
If you answered yes, which medication?
.....

6. Are you taking any regular medication (including any complementary medicines such as St John's Wort)? ☐ Yes ☐ No
If yes, which .....

7. Do you know the name of the pill you are currently taking? ☐ Yes ☐ No
If yes .....

8. Have you ever been advised not to use the progestogen-only pill? ☐ Yes ☐ No

9. Would you like to discuss other methods of contraception such as long-acting methods that you do not have to remember to take each day? ☐ Yes ☐ No

10. Do you feel frightened of your partner or others at home? ☐ Yes ☐ No

☐ I confirm that I have read the information sheet and have answered the questions to the best of my knowledge.

Signature .....

Ref: 0582_DEC2016 | December 2016

Pill and Patch Resupply Clinic

Questionnaire for Combined Hormonal Contraception

Name ..... **Date of Birth** .....

1. Have you been late or missed taking any pills/patches in the last 3 months? ☐ Yes ☐ No
2. Are you over 34 years old and have you smoked in the last 12 months? ☐ Yes ☐ No
3. Have you ever had migraine? These are bad headaches, often only on one side, that make you feel sick in your stomach or make it hard to be in light. They may affect your ability to see or involve tingling, pins and needles or numbness in the face, arm or leg. ☐ Yes ☐ No
4. Do you have any abnormal vaginal bleeding, for instance after sex or at a time when you should not bleed? ☐ Yes ☐ No
5. Have you had or do you currently have any of the following conditions:

High blood pressure	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Thrombosis (blood clots in legs or in the lungs)	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Liver disease or Jaundice or Gall stones	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No

6. Since your last visit to our clinics have you had any of the following:

Pregnancy	☐ Yes ☐ No	Any serious illness	☐ Yes ☐ No
Breast problems	☐ Yes ☐ No	Any major surgery	☐ Yes ☐ No

7. Have your mother, father, brother or sister had a stroke, heart attack or thrombosis when they were under the age of 46? ☐ Yes ☐ No
8. Have your mother, father, brother or sister had breast cancer when they were under the age of 46? ☐ Yes ☐ No
9. Do you have any known allergic reactions to medicine? ☐ Yes ☐ No
   If you answered yes, which medication? .....
10. Are you taking any regular medication (including any complementary medicines such as St John's Wort)? ☐ Yes ☐ No If yes, which
11. Have you ever been advised not to use the combined pill or patch? ☐ Yes ☐ No
12. Would you like to discuss other methods of contraception such as long-acting methods that you do not have to remember to take each day? ☐ Yes ☐ No
13. Do you feel frightened of your partner or others at home? ☐ Yes ☐ No

☐ I confirm that I have read the information sheet and have answered the questions to the best of my knowledge.

Signature .....

Ref: 0582_DEC2016 | December 2016