CONFIDENTIAL

NHS Pharmacy Contraception Service pre-consultation questionnaire

To provide the contraceptive pill safely, we need to ask you a number of questions. Please complete this form before your consultation with the pharmacist.

When completing the form, please follow any instructions provided by the pharmacy team.

If you are having any problems with your medicine or would like to consider alternative contraceptive options, please discuss this with the pharmacist.

***Note to the pharmacy team**: Advise patients to answer all the questions. Patients only requesting an ongoing supply of a progesterone only pill (POP) should be advised to ignore the shaded Screening questions.*

Patient details

Name:		Date of birth:		Age:	
Address:		Postcode:			
Email address:		Telephone number:			
Ethnicity:		NHS number:			
GP Practice:		Consultation date:			

Screening questions

1. Are you wanting to start a new contraceptive pill or restart a previously used contraceptive pill? (If yes, go to question 6)	☐ Yes	☐ No
2. Have you previously had a supply of your contraceptive pill from your general practice, sexual health clinic or a pharmacy?	☐ Yes	☐ No
3. Are you wanting to change your current contraceptive pill?	☐ Yes	☐ No
4. Have you missed any pills at any point or had a gap of any duration since your last supply?	☐ Yes	☐ No
5. Have you had any problems with or side effects from your contraceptive pill?	☐ Yes	☐ No
6. Are you taking any other prescribed medication?	☐ Yes	☐ No
7. Are you taking any over the counter medicines or herbal products?	☐ Yes	☐ No
8. Have you had your blood pressure checked within the last three months?*	☐ Yes	☐ No
Please provide you blood pressure reading if known*:	/	
9. Are you pregnant, or might you be pregnant?	☐ Yes	☐ No
10. Do you have long periods of immobility?*	☐ Yes	☐ No

Cardiovascular health

11. Are you a smoker (including vaping / use of e-cigarettes)?* (If no, go to question 13)	☐ Yes	☐ No
12. If you are a smoker, would you like help giving up?*	☐ Yes	☐ No
13. What is your weight?*		***Pharmacy use*** BMI:
14. What is your height?*		
15. Do you have a current or past history of ischaemic heart disease, vascular disease, stroke, or transient ischaemic attack (TIA)?**	☐ Yes	☐ No
16. Do you have diabetes?* (If no, go to question 18)	☐ Yes	☐ No

17. If yes, has this affected any of your organs (causing retinopathy, nephropathy, or neuropathy)?*	☐ Yes	☐ No
18. Have you ever had a deep vein thrombosis or pulmonary embolus?*	☐ Yes	☐ No
19. Do you have a current or past history of any heart disease?*	☐ Yes	☐ No
20. Do you have parents, siblings or children who have had heart disease or strokes under the age of 45?*	☐ Yes	☐ No
21. Do you have parents or siblings that have had a deep vein thrombosis or pulmonary embolus under the age of 45?*	☐ Yes	☐ No
22. Do you have any blood clotting illnesses / abnormalities?*	☐ Yes	☐ No
23. Do you have any problems with your heart muscle or any impaired heart function?*	☐ Yes	☐ No
24. Do you have or have you been diagnosed with atrial fibrillation?*	☐ Yes	☐ No
Neurological health		
25. Do you suffer from migraines?* (If no, go to question 28)	☐ Yes	☐ No
26. If so, do you experience visual symptoms or changes in sensation or muscle power on one side of your body?*	☐ Yes	☐ No
27. If you suffer from migraines, did your first attack occur when you started taking your contraceptive pill?*	☐ Yes	☐ No
Cancers		
28. Do you have any past or current history of breast cancer?	☐ Yes	☐ No
29. Do you have any undiagnosed breast symptoms?*	☐ Yes	☐ No
30. Do you have any family history of breast cancer under the age of 50?*	☐ Yes	☐ No
31. Do you have any past or current history of any other cancer?	☐ Yes	☐ No
Gastro-intestinal health		
32. Do you have any form of liver disease or liver impairment?	☐ Yes	☐ No
33. Do you have gall bladder disease that causes you symptoms or is medically managed?*	☐ Yes	☐ No
34. Do you suffer from acute/active inflammatory bowel disease or Crohn's disease?	☐ Yes	☐ No
35. Have you had any bariatric surgery or any other surgery that has reduced your ability to absorb things from your stomach?	☐ Yes	☐ No
36. Do you suffer from Cholestasis, a condition caused by blocked or reduce flow of bile fluid?*	☐ Yes	☐ No
Other health conditions		
37. Do you have any planned major surgeries?*	☐ Yes	☐ No
38. Have you ever been diagnosed with Anti phospholipid syndrome (APS) (also known as Hughes syndrome) with or without Lupus?*	☐ Yes	☐ No
39. Have you ever had an organ transplant that has resulted in complications?*	☐ Yes	☐ No
40. Do you have severe kidney impairment or acute renal failure?*	☐ Yes	☐ No
41. Have you been diagnosed with Acute porphyria?***	☐ Yes	☐ No

Thank you for completing this form. Please return it to the pharmacist when you are ready.

For the pharmacist:

* *Question relevant to COC pill only.*

** *For POP, TIA (first attack only) if taking the method when the event occurred.*

*** *Question relevant to POP only.*