**The Miller Practice**
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# Repeat combined contraceptive pill request

Name _____

Date of birth _____

Phone number / Email _____

What is your current contraceptive pill? _____

Have you been on this pill for longer than 9 months Yes ☐ No ☐

Are you experiencing any unwanted side effects? Yes ☐ No ☐

Is your bleeding pattern regular? Yes ☐ No ☐

Do you get any bleeding in between your periods? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

If yes how many cigarettes do you smoke per day? _____

What is your current weight? _____

What is your current blood pressure reading _____
(Best of three readings)

Do you get migraine with aura (severe headache) Yes ☐ No ☐

Have you ever had breast cancer or do you have a first degree relative with breast cancer (mother, sister, child)? Yes ☐ No ☐

Have there been any new cases blood clots for you or in your family since your last prescription? Yes ☐ No ☐

Do you know what to do if you miss a pill? (see link if no) Yes ☐ No ☐

If you would like your prescription sent to a pharmacy please let us know where

_____

Signed _____

We may call you to discuss the answers you put on this form

https://www.nhs.uk/conditions/contraception/miss-combined-pill/