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Dr. A. Razvi, MbCHB, nMRCGP

Repeat Prescription Request: Oral Contraceptive Pill.
Please fill out this form and email it to Yewtree.medicalcentre@nhs.net.

Name:		**Date:**	
Date of birth:			
Address:			
Is this a repeat medication Request?		*If you are requesting a new medication, please make an appointment to see your GP.*	
Are you having any side effects?		*If you are having side effects, please make an appointment and discuss these with your GP.*	
Do you suffer with Migraine, Headaches?		*If you do have Migraines, please discontinue your pill and see your GP.*	
Do you have a history of blood clots?		*If you do have a history of Blood Clots you should not be on the combined oral contraceptive pill.*	
Do you have a family history of Breast Cancer?		*If there is a new diagnosis of breast cancer in your family, please make an appointment and discuss this with your GP.*	
Do you smoke? If so, how many cigarettes a day?		*If you do smoke, please state the **number of cigarettes you smoke per day.***	
How old are you?			
What is your weight?		*A scale is available in the reception area.*	

What is your height?		*A height measuring station is available in the reception area.*
What is your Blood Pressure?		*Please use the blood pressure machine in the reception area and attach your result to this request form.*
When was your last cervical smear test:		*If you are over 25, you should have had a cervical smear test. If you have had a smear test, but it was more than 3 years ago, please book an appointment with the practice nurse for a repeat test.*