Pill Check

In order for us to complete your medication review to continue with the contraceptive pill, please fill out the following details.

Name .... DOB.................................Address..................................

Date ....

How much exercise do you do in a week? ....

Do you smoke? If yes how much? ....

How much alcohol do you drink per week? ....

Do you have a healthy diet? ....

Blood pressure reading ....

(Please sit for 10 minutes. Apply the cuff with the tube placed on the inside of your elbow and press the start button.)

Weight (kg) ....

Do you have any issues with the pill? e.g. headaches?

....

When you are finished please give hand this form into the Surgery or e-mail to gram.donotreply.moraycoastmedicalpractice@nhs.scot

Thank you