Automated Pill Check Protocol

Name:

DOB:

Address:

Postcode:

Weight:

Blood pressure:

Smoker? Yes ☐ No ☐

Current pill name: ……..

Have you had any problems with your pill? Yes ☐ → please make an appointment

No

Do you suffer with migraines? Yes ☐ → please make an appointment

No

Is there any personal or family history of blood clots? Yes ☐ → please make an appointment

No

Have you had any other medical problems since your last prescription? Yes ☐ → please make an appointment

No

Please confirm you have read the leaflet on long-acting reversible contraception ☐

Please confirm you have read the information on breast examination ☐

Submit and send pill request