TILEHURST SURGERY
PERIOD DELAY MEDICATION REQUEST FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:		**DOB:**	**Age:**
Registered doctor:	**Tel Home:**	**Tel Mobile:**	
Email:			

BP:	**Height:**	**Weight:**	**BMI:**	
Smoking status	☐ Non-smoker	☐ Ex-smoker	☐ Current smoker	Number of cigarettes/day:
If you smoke, we strongly advise that you stop. If you would like help with this, please speak to reception about our in-house clinic				
Do you drink alcohol?	☐ No	☐ Yes	Number of units per week	(1 unit = small glass of wine or half pint beer)
Do you exercise?	☐ Never	☐ Once a month or less	☐ Once a week	☐ Several times a week	☐ 5 times a week or more
Period Due Date:				
Date of Travel:				
Duration of Stay:				
Travel Destination:				

Do you have any bleeding between your periods?	☐ Yes (Book appointment) ☐ No
Do you have any bleeding after sex?	☐ Yes (Book appointment) ☐ No
If over 25, have you had a smear in the last 3 years? If not please book in at reception to have this done	
Have you ever had a stroke, a blood clot in your legs or your lungs, a heart attack or any heart problems? ☐ Yes ☐ No **If yes please give details:**	
Have your mother, father, brother or sister had a blood clot in their legs or lungs aged under 60 years? ☐ Yes ☐ No **If yes please give details of relative's relationship to you and age at which they had a clot:**	
Has your mother, father, brother or sister had a heart attack or stroke aged under 60 years? ☐ Yes ☐ No **If yes please give details of relative's relationship to you and age at which they had heart attack or stroke:**	
Do you take medication for epilepsy? ☐ Yes ☐ No	

If you would like more information, please see *www.fpa.org.uk or book to discuss these options with a family planning nurse/doctor*
Would you like a sexual health screen? Please see www.royalberkshire.nhs.uk/sexualhealth.htm for further details

Informed Consent:
I have answered the above questions to the best of my knowledge and am aware of the risks to my health if the information provided is inaccurate ☐
I am requesting this medication for my sole use only and not on the behalf of another person ☐
I know that if I experience any abnormal vaginal bleeding or migraines to contact my doctor for further advice ☐

Print and Sign:	Date:

Admin use only:- Read Coded? ☐ Yes ☐ No Processed by: _____