Quality Health Matters

Strand Medical Group

In order for us to prescribe Combined Oral Contraceptive, please fill in the form below.
Thank you.

Surname: .... First name: .... DOB: ....

Home phone no: .... Mobile phone no: ....

I give permission for the surgery to leave a message: *
** Please circle all relevant*

With a third party | Home number | Mobile voicemail

I give permission for the surgery to text to my mobile: YES: ☐ NO: ☐

Please note that consent to all the above will be assumed if no options are marked.
This arrangement will remain in force until you advise us in writing that you wish to change it.

LIFE STYLE QUESTIONS

Height: .... Weight: ....

Please attach today's Blood Pressure reading taken in the waiting room.

Do you smoke?

YES: ☐ If yes, how many: .... day .... week .... month

NO: ☐ Ex-smoker: ☐ Years ago: ....

Never smoked: ☐

Has your health changed within the last year? Yes ☐ No ☐

If yes, please state how:

Signature: .... Date: ....