GREENSANDS **MEDICAL PRACTICE**

**If you have been advised that your medication review is due please fill in this form.**

**Your details:**

| | |
|---|---|
| Full name: | |
| Date of birth: | |
| Phone number: | |

**Medication review:**

Do you have any side effects or concerns about your medication? ○ Yes ○ No

Do you know when and how to take your medication? ○ Yes ○ No

Have you stopped taking any medication on your repeat list? ○ Yes ○ No

If yes, please list medication that you have stopped in the box below:

| |
|---|
| |

**Health review:**

Are you an ex-smoker? ○ Yes ○ No Do you currently smoke? ○ Yes ○ No

If yes please visit www.smokefreebedfordshire.co.uk or call 0800 0130 553 for support

If you know your current weight and height please enter it below:

| | |
|---|---|
| Weight: | Height: |

**Blood pressure review (only complete if you have a home blood pressure machine):**

Please fill in your **last 3** blood pressure readings. These readings should have been taken on **different days** in the **last 3 months**.

| | | |
|---|---|---|
| 1) | 2) | 3) |

**Thank you for taking the time to complete this form. This information will go to your doctor. A message will appear on your next prescription advising you on what your doctor wishes you to do next.**