pharmadoctor

Period Pain
Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	Would you like your GP to be informed of this consultation? Yes ☐ No ☐	

Please answer the following questions

Do you have any allergies? Yes ☐ No ☐ *If yes, please describe the allergy/reaction*	Do you have any recent or past medical history of note? Yes ☐ No ☐ *If yes, please provide details*
Have you ever had an allergic or anaphylactic reaction to naproxen, aspirin, ibuprofen or any other medication? Yes ☐ No ☐ *If yes, please provide details*	Do you have any liver problems? Yes ☐ No ☐ *If yes, please provide details*
Are you pregnant, planning pregnancy or is there a possibility you may be pregnant? Yes ☐ No ☐	Do you have kidney problems? Yes ☐ No ☐ *If yes, please provide details*
Are you currently breast-feeding? Yes ☐ No ☐	Have you been told by your doctor you have an intolerance to any sugars (e.g galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)? Yes ☐ No ☐ *If yes, please provide details*
Do you have any problems with your stomach or gut (intestine), such as an ulcer or bleeding? Yes ☐ No ☐	Do you have any heart problems? Yes ☐ No ☐ *If yes, please provide details*
Do you have high blood pressure, diabetes, high cholesterol or are you a smoker? Yes ☐ No ☐ *If yes, please provide details*	Do you have difficulties conceiving or are you undergoing investigation of fertility? Yes ☐ No ☐
Did you start experiencing period pain more than a year after starting menstruation? Yes ☐ No ☐	Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)? Yes ☐ No ☐
Do you have any symptoms? Yes ☐ No ☐ *If yes, please provide details*	Do you have a history of gastrointestinal diseases such as ulcerative colitis or Crohn's disease? Yes ☐ No ☐
Do you have any autoimmune condition such as systemic lupus erythematosus? Yes ☐ No ☐	Do you have asthma, allergies (like hay fever), polyps or rhinitis? Yes ☐ No ☐

Please list all your current prescription medication including any medication you buy over the counter.

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CONSENT

I have received information on the risks and benefits of the treatment and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given.

Signature of patient, parent or guardian _____ **Date** _____

HEALTHCARE PROFESSIONAL USE ONLY		
Assessment	**Details**	**Date**
Blood pressure		
Further information that may be relevant		

HEALTHCARE PROFESSIONAL USE ONLY		
Non-supply/administration		
I confirm that the patient did NOT receive the medication ☐	**Patient referred to GP** ☐	
Reason for non-supply/administration		
Supply/administration		
Drug brand, batch number and expiry date.	Date	Cost
I confirm that the patient is not contraindicated based on the information provided by the PGD		☐
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur		☐
I have provided the patient with an information leaflet (PIL) for the treatment I am supplying, and advised them to read it		☐
Healthcare Professional Name	**Healthcare Professional Signature**	