**A picture containing graphical user interface

Description automatically generated  
Menopause / HRT Questionnaire**

Please read the information on our website’s Menopause page and return the filled-out questionnaire to the surgery prior to your consultation.

|  |  |
| --- | --- |
| **Full Name** |  |
| **Date of Birth** |  |
| **Blood pressure \* Important to do prior consultation\***  (from home machine reading or come into the surgery waiting room to do this prior to your doctor’s appointment). |  |
| **Weight** |  |
| **Height** |  |
| **Do you smoke and if so, for how long and how many** **a day?** |  |
| **How much alcohol do you typically drink a week?** |  |

**Score these symptoms out of 10 (Zero = no symptoms, 10= severe Symptoms)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Daytime sweats or flushes |  |  | Brain Fog/ loss of concentration/loss of memory |  |
| Night sweats or flushes |  | Vaginal dryness/ soreness/pain with intercourse |  |
| Unable to sleep |  | Formication (sensation of something crawling all over you) |  |
| Anxiety/panic attacks |  | General aches and pains |  |
| Irritability/anger |  | Urine infections/urgency/incontinence |  |
| Mood changes |  | Hair loss |  |
| Irritability |  | Migraines |  |
| Tearfulness /depression |  | Headaches |  |
| Forgetfulness |  | Skin Dryness |  |
| Poor or no libido |  |  | |

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| --- | --- |
| What hormonal treatment or contraception are you on? Roughly how long have you been on this? |  |
| What have you already tried to help your menopausal symptoms? |  |
| If you are on HRT, do you have any side effects of treatment? |  |
| Do you want to continue with HRT? |  |
| Do you want to start HRT if you are not already on it? |  |
| Have you got a Mirena coil in place and if so when/where was this fitted? |  |
| Have you had a hysterectomy? Was this a full hysterectomy or partial (i.e., did they leave your cervix?) |  |
| Do you have a history of endometriosis? |  |
| When was your last period and what have your periods been like over the last year? |  |
| Do you have any unexpected spotting or bleeding? |  |
| Have you or a close family relative (i.e., parent or sibling) ever had breast cancer? If so, what age were you/they when it was first diagnosed? |  |

|  |  |  |
| --- | --- | --- |
| **Have you ever had and if so, when?** | **Yes / No** | **Date** |
| Clots in the legs or lungs |  |  |
| Cardiac disease or stroke |  |  |
| Heart attack or Angina |  |  |
| Active liver disease |  |  |
| Migraine |  |  |

|  |  |
| --- | --- |
| Do you have a personal history or family history of weak bones or Osteoporosis? |  |
| Any new medical problems? |  |
| Are you up to date with breast and cervical screening? |  |

|  |  |
| --- | --- |
| Signature  Name: | Date |

**PLEASE NOTE THIS WILL NOT BE READ BY A HELATHCARE PROFESSIONAL UNTIL YOUR CONSUTLATION SO DO NOT WRITE ANYTHING ON THIS FORM THAT NEEDS AN URGENT ANSWER.**

**IF YOU HAVE SOMMETHING YOU NEED TO DISCUSS WITH THE DOCTOR URGENTLY, PLEASE BOOK AN URGENT APPOINTMENT FOR THIS SEPARATELY.**