Crossley Street Surgery

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				

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.