**\*\*\*GP - PLEASE COMPLETE LAST PAGE ONCE REVIEWED\*\*\***

**\*\*\*RECEPTION – REVIEW PAST PAGE FOR ACTIONS BEFORE SCANNING\*\*\***

**---------------------------------------------------------------------------------------------------------------------------------**

**PENNY LANE SURGERY**

**HRT check-up questionnaire**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pronouns (please circle): She / He / They

How long have you been taking HRT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which HRT are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of symptoms**

|  |  |
| --- | --- |
| **Vasomotor**  |  |
| Do you have hot flushes and night sweats? | Yes □ No □ |
| How often are you experiencing these? |  |
| Are you experiencing poor sleep? | Yes □ No □ |
| Are you experiencing fatigue? | Yes □ No □ |
| Are you experiencing joint pains/stiffness? | Yes □ No □ |
| Are you experiencing muscles aches/cramps? | Yes □ No □ |
| Are you experiencing headaches? | Yes □ No □ |
| Are you experiencing itchy skin? | Yes □ No □ |
| Are you experiencing palpitations? | Yes □ No □ |
| Are you experiencing brain fog? For example: poor memory, struggling to find words, poor concentration | Yes □ No □ |
| **Genito-urinary** |  |
| Are you experiencing a sore/dry/itchy vulval area/vagina? (including painful sex) | Yes □ No □ |
| Are you experiencing an overactive bladder? (needing to wee more often/at night) | Yes □ No □ |
| Are you experiencing increased urinary urgency? (having to run to the loo) | Yes □ No □ |
| Have you had any urinary incontinence when laughing/coughing/sneezing? | Yes □ No □ |
| Have you noticed any vaginal prolapse/heaviness down below? | Yes □ No □ |
| **Overall** |  |
| Do you think your symptoms have improved since starting HRT? | Yes □ No □ |

**Menstrual cycle**

|  |  |
| --- | --- |
| **Has your period/menstrual cycle…** |  |
| * Stopped?
 | Yes □ No □ |
| *If yes, please note when your last period was*  |  |
| * Have you had any bleeding between periods or after penetrative sex?
 | Yes □ No □ |
| * Are you bleeding all the time?
 | Yes □ No □ |

**A bit more about your medical history…**

|  |  |
| --- | --- |
| Have you had a hysterectomy (womb removed)? | Yes □ No □ |
| *If yes, was it a total hysterectomy (ie did they remove your cervix too)?* | Yes □ No □ Unsure □ |
| Have you had an endometrial ablation? | Yes □ No □ Unsure □ |
| Have you ever been diagnosed with endometriosis? | Yes □ No □ Unsure □ |
| Do you have a history of breast cancer? | Yes □ No □ |
| Do you have a family history of breast cancer? | Yes □ No □ |
| *If yes, please note who this is (which relatives)* |  |
| Do you have any current breast lumps? | Yes □ No □ |
| Are you a current smoker? | Yes □ No □ |
| What is your weekly average alcohol intake? |  |
| *Please use this calculator if you need help: https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator* |
| Have you ever had a PE (pulmonary embolism)/DVT (deep vein thrombosis)/have you ever been diagnosed with any other clotting disorder? | Yes □ No □ |
| Do you have a history of migraines? | Yes □ No □ |
| Do you have any other form of cardiovascular disease? (ie have you had any issues with your heart or blood circulation) | Yes □ No □ |
| Do you own a blood pressure monitor?  | Yes □ No □ |
| *If yes, please record a blood pressure for us and document here:* |  |
| What is your current weight? |  |
| What is your current height? |  |
| Do you require contraception? (please answer no if your periods stopped over 12months ago) | Yes □ No □ |
| Do you have a Mirena coil in place at the moment? | Yes □ No □ |

Thank you for completing this questionnaire.

**Once you have handed this form in to reception, we will contact you with one of the following outcomes:**

1. **Confirming your repeat prescription and continuation on HRT**
2. **We will book you an appointment to discuss your future HRT decisions. This may be over the telephone or in person.**

**------------------------------------------------------------------------------------------------------------------------**

**GP TO COMPLETE:**

Prescription issued. No action required by reception:

Please book appointment with GP to discuss:

Routine Urgent

F2F Telephone

**RECEPTION TO COMPLETE:**

Please tick to confirm apt has been booked: (Scan to MR once apt booked)

Receptionist initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_