**Menopause/HRT questionnaire**

**Please complete and return the questionnaire to the surgery prior to your consultation.**

**Name:**

**DOB:**

**Date:**

1. **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).
2. **Weight in Kg**
3. **Height in cm**
4. **Do you smoke and if so, for how long and how many** **a day?**
5. **How much alcohol do you typically drink a week?**
6. **Score these symptoms out of 10 (Zero = no symptoms, 10= severe Symptoms)**

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

1. **What hormonal treatment or contraception are you on? Roughly how long have you been on this?**
2. **What have you already tried to help your menopausal symptoms?**
3. **If you are on HRT, do you have any side effects of treatment?**
4. **Do you want to continue with HRT?**
5. **Do you want to start HRT if you are not already on it?**
6. **Have you got a Mirena coil in place and if so when/where was this fitted?**
7. **Have you had a hysterectomy? Was this a full hysterectomy or partial (ie did they leave your cervix?)**
8. **Do you have a history of endometriosis?**
9. **When was your last period and what have your periods been like over the last year?**
10. **Do you have any unexpected spotting or bleeding?**
11. **Have you or a close family relative (ie parent or sibling)** **ever had breast cancer? If so, what age were you/they when it was first diagnosed?**
12. **Have you ever had and if so, when?**
* **Clots in the legs or lungs**
* **Cardiac disease or stroke**
* **Heart attack or Angina**
* **Active liver disease**
* **Migraine**
1. **Do you have a personal history or family history of weak bones or Osteoporosis?**
2. **Any new medical problems?**
3. **Are you up to date with breast and cervical screening?**

Please return forms to practice inbox marked “For information only, to be scanned to notes to inform doctor during consultation”.

**PLEASE NOTE THIS WILL NOT BE READ BY A HEALTHCARE PROFESSIONAL UNTIL YOUR CONSULTATION SO PLEASE 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.**