NAME: _____ DOB: _____

LANDLINE TELEPHONE: _____ MOBILE NUMBER: _____

BLOOD PRESSURE: _____ HEIGHT: _____

WEIGHT: _____

WHY DO YOU TAKE HRT?

☐ EARLY MENOPAUSE (BEFORE 45)

☐ MENOPAUSAL SYMPTOMS

DATE OF LAST PERIOD: _____

HAVE YOU HAD A HYSTERECTOMY? YES ☐ NO ☐

HAVE YOU HAD A MIRENA COIL INSERTED? IF SO, WHAT DATE? _____

DO YOU SMOKE? YES ☐ HOW MANY PER DAY? ☐ NO ☐ EX SMOKER ☐

DATE STOPPED: _____

HOW MANY UNITS OF ALCOHOL DO YOU DRINK PER WEEK? PLEASE CIRCLE:

NON-DRINKER 1-2UNITS 3-4UNITS 5-6UNITS

7-9UNITS 10+ UNITS

HAVE YOU EVER SUFFERED WITH ANY OF THE FOLLOWING? (PLEASE TICK WHERE APPROPRIATE)

- HEART ATTACK
- STROKE
- BLOOD CLOT (EG, LEG OR LUNG)
- BREAST CANCER
- ENDOMETRIAL CANCER
- LIVER OR GALLBLADDER DISEASE

DO YOU HAVE ANY FAMILY HISTORY (PARENT OR SIBLING) OF ANY OF THE FOLLOWING? (PLEASE TICK WHERE APPROPRIATE)

- BLOOD CLOTS
- BREAST CANCER
- ENDOMETRIAL CANCER
- HEART ATTACK
- STROKE

ARE YOU CURRENTLY USING CONTRACEPTION? _____

DO YOU FEEL YOUR HRT IS EFFECTIVELY CONTROLLING YOUR SYMPTOMS? _____

HAVE YOU BEEN EXPERIENCING SIDE EFFECTS SINCE STARTING HRT? _____

HAVE YOU CONSIDERED REDUCING OR STOPPING HRT? _____

HAVE YOU EXPERIENCED ANY PERSISTANT, UNEXPECTED BLEEDING OR INCREASED BLEEDING? _____

ARE YOU AWARE AOF THE INCREASED RISK OF BLOOD CLOTS AND SOME CANCERS ASSOCIATED WITH HRT? _____

ARE YOU UP-TO-DATE WITH YOUR CERVICAL SCREENING (SMEAR) AND BREAST SCREENING? _____

DO YOU REGULARLY SELF CHECK YOUR BREASTS? _____

SIGNATURE: _____

DATE: _____