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: