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

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**PENNY LANE SURGERY**

**HRT pre-appointment questionnaire**

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

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

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

**What are your symptoms?**

|  |  |
| --- | --- |
| **Vasomotor** |  |
| 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 □ |

**What other changes have you noticed?**

|  |  |
| --- | --- |
| **Body changes** | *Tick all that apply* |
| Increased facial hair |  |
| Putting weight on around tummy area |  |
| Thinning hair on head |  |
| **Is your period/menstrual cycle…** |  |
| * Lighter |  |
| * Heavier |  |
| * Shorter |  |
| * Longer |  |
| * Less frequent |  |
| * More frequent |  |
| * Stopped |  |
| *If yes, please note when your last period was* |  |
| * Chaotic cycle |  |
| * Have you had any bleeding between periods? | 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 was (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? | Yes □ No □ |
| Do you have a coil in place at the moment? | Yes □ No □ |

**Information leaflet**

Please confirm you have read the provided information leaflet; this will help you make an informed decision with the GP should you want to request HRT prescription.

Signed to confirm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please see the below websites for further information/support including lifestyle adaptions and non-hormonal treatments:

<https://www.menopausematters.co.uk/>

<https://www.womens-health-concern.org/help-and-advice/factsheets/>

Thank you for completing this pre-appointment questionnaire.

**Once you have handed this form in to reception, we will contact you to book an appointment. This may be over the telephone or in person.**

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

**RECEPTION TO COMPLETE:**

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

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