****Please only complete the following questionnaire if you are requesting repeat medication as part of your routine HRT review.

Please note this form is not appropriate for those wishing to start new medication or change their current HRT. If this is the case please contact the surgery to arrange a telephone consultation with your GP.

Please complete ALL questions on the form. Incomplete forms will cause a delay to your prescription.

NAME……………………………………………………………………………………………………………………………………

DAT E OF BIRTH………………………………………………………………………………………………………………………

CONTACT TELEPHONE NUMBER……………………………………………………………………………………………

1. Name of HRT you are requesting………………………………………………………………………………
2. When was your last period?

<1 month 1-6months 6-12 months >1 year

1. Have you had a hysterectomy?.................................................................................Y/N
2. Do you CURRENTLY have a Mirena coil fitted?.........................................................Y/N
   1. If yes, what date was your Mirena coil fitted?

Not applicable <1 month 1-6months 6-12 months >1 year

1. Do you smoke?......................................................................................................... Y/N

* If yes – we strongly recommend that you consider stopping. If you would like to access SMOKING CESSATION SUPPORT please call 0300 126 5700.

1. What is your current weight in kilograms?.....................................................................
2. What is your height in cm?.............................................................................................
3. What is your BLOOD PRESSURE?.....................................................................................
4. Have you been experiencing any side effects since you started your HRT?...................Y/N

If yes please provide details……………………………………………………………………………

…………………………………………………………………………………………………………………………………

10. Do you have regular vaginal bleeding with your HRT?....................................................Y/N

11. Have you experienced any unexpected / unusual vaginal bleeding?..............................Y/N

1. Do you have any breast lumps that have not been checked by a doctor?.....................Y/N
2. Have you ever had any blood clots in the lung or leg (DVT or PE)…………………….…………Y/N
3. Have you ever had a heart attack or stroke?..................................................................Y/N
4. Have you ever had breast or endometrial (womb) cancer?............................................Y/N
5. Have you ever had liver or gallbladder disease?.......................................................... ..Y/N
6. Do you have a family history of any of the following? (please circle all that apply)

*Blood clot (DVT/PE)/Breast or Endometrial cancer/ Heart Attack /Stroke /None of the above*

\*\*\*\*\*HRT can increase you risk of breast cancer, endometrial cancer, DVT or PE and cardiovascular disease. These risks will have been discussed with you when you were first prescribed HRT. \*\*\*\*\*

For further information on the risks of HRT please visit:

https://www.nhs.uk/conditions/hormone-replacement-therapy-hrt/risks/

Please select one of the following options:

1. I understand the risks of HRT but I would like to continue my prescription due to improvement in my menopause symptoms.
2. I would like to discuss these risks with my GP before making a decision on my ongoing HRT prescription.

Thank you for completing this form. Your GP will review your responses.

Please allow 72 hours for this prescription. If there are any queries or problems with any of your responses a GP will contact you by telephone to discuss things further.