**Menopause/HRT questionnaire**

Please read the information on the New Forest PCN website Menopause page [www.newforestpcn.co.uk/network-services/healthandwellbeing/menopause](http://www.newforestpcn.co.uk/network-services/healthandwellbeing/menopause) and **return the filled-out 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**
3. **Height**
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)**

**Symptom Score**

Daytime sweats or flushes \_\_\_\_

Night sweats or flushes \_\_\_\_

Unable to sleep \_\_\_\_

Anxiety/panic attacks \_\_\_\_

Irritability/anger \_\_\_\_

Mood changes \_\_\_\_

Irritability \_\_\_\_

Tearfulness /depression \_\_\_\_

Forgetfulness \_\_\_\_

Brain Fog/ loss of concentration/loss of memory \_\_\_\_

Skin Dryness \_\_\_\_

Formication (sensation of something crawling all over you) \_\_\_\_

General aches and pains \_\_\_\_

Poor or no libido \_\_\_\_

Vaginal dryness/ soreness/pain with intercourse \_\_\_\_

Urine infections/urgency/incontinence \_\_\_\_

Hair loss \_\_\_\_

Migraines \_\_\_\_

Headaches \_\_\_\_

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 (i.e. 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 (i.e. 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 DO NOT WRITE ANYTHING ON THIS FORM THAT NEEDS AN URGENT ANSWER.**

**IF YOU HAVE SOMETHING YOU NEED TO DISCUSS WITH THE DOCTOR URGENTLY, PLEASE BOOK AN URGENT APPOINTMENT FOR THIS SEPARATELY.**

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