***Personal Details***

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** |   | **Last Name** |   |
| **Date of Birth** |   |  |
| **Postcode** |   |
|  |  |
| **Current Weight** | \_\_\_\_\_\_\_\_ kg |  |
| \_\_\_\_ st \_\_\_\_ lb |
| **Height** | \_\_\_\_\_\_\_ cm |
| \_\_\_\_ ft \_\_\_\_ in |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ethnicity** |  | White - British |  | Asian/Asian British - Indian |
|  |  | White - Irish |  | Asian/Asian British – Pakistani |
|  | White - Other |  | Asian/Asian British – Bangladeshi |
|  | Mixed - White and Black Caribbean |  | Asian/Asian British – Chinese |
|  | Mixed - White and Black African |  | Any other Asian background |
|  | Mixed - White and Asian |  | Any other ethnic group |
|  | Mixed - Any other mixed background |  |  |
|  | Black/Black British - Caribbean |  |
|  | Black/Black British - African |  |
|  | Any other Black background |  |

***Menopause Symptoms***

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| --- | --- | --- | --- |
|  | Not at all | Sometimes | All the time |
| Hot flashes/flushes – your body feels hot and sweaty during the day or night? |  |  |  |
| Night sweats - You feel hot or cold at night and wake up with wet sheets and may need to change nightwear? |  |  |  |
| Palpitations - Does it feel like your heart beats quickly or strongly?  |  |  |  |
| Mood swings or changes - Do you feel tense or nervous? Do you have attacks of anxiety or panic? Have you lost interest in most things? Are you feeling unhappy or depressed? Are you more irritable? |  |  |  |
| Fatigue - Are you feeling more tired and lacking in energy than before?  |  |  |  |
| Sleep disturbances - Do you have more difficulty sleeping than before?  |  |  |  |
| Vaginal dryness - Do you have vaginal dryness? |  |  |  |
| Decreased libido (sex drive) - Have you lost interest in sex? |  |  |  |
| Breast tenderness – sore breasts? |  |  |  |
| Weight gain or weight changes? |  |  |  |
| Urinary problems or incontinence - Do you have bladder leakage or you are not able to get to the toilet quick enough compared to before? |  |  |  |
| Joint or muscle pain - Do you have muscle aches or joint pains? |  |  |  |
| Memory problems or difficulty concentrating - Have you noticed difficulty in concentrating more recently? Do you experience brain fog more often than before? Do you notice problems with your memory more recently? |  |  |  |
| Headaches |  |  |  |
| Changes in skin, such as dryness or acne |  |  |  |
| Vertigo – everything is spinning. It is more than just feeling dizzy. Can have blurred vision, hearing problems, sweating or feeling sick. |  |  |  |

***Menstrual Cycle/Periods***

|  |  |
| --- | --- |
| What was the date of your last period? | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ |

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| --- | --- | --- | --- | --- |
| Are you still having periods? |  | Yes |  | No |
| If **No** | Have you had any bleeding which occurred more than 1 year after your last period |  | Yes |  | No |
|  |
| If **Yes** | Are your periods regular or irregular? |  | Regular |  | Irregular |
|  | On average how many days are there between periods (i.e. day 1 of period to the day 1 of the next period)? *You may give a range if it is irregular* | \_\_\_\_\_\_\_\_\_\_ days |
| Are there any recent changes in the heaviness/lightness of flow? |  |
|  | Do you have any spotting/bleeding between periods? |  |

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| --- | --- | --- | --- | --- |
| Have you recently noticed any bleeding or pain after sex? |  | Yes |  | No |
| In the past have you had any treatment/s to the lining of the womb/uterus (e.g. endometrial ablation)? |  | Yes |  | No |
| Have you had your ovaries removed? |  | Yes |  | No |
| Have you ever suffered from endometriosis? |  | Yes |  | No |
| Date of last smear test? *If aged 25-49 this is every 3 years**If aged 50-64 this is every 5 years**If you are due for a smear test please contact our reception team to arrange an appointment for this* | \_ \_ / \_ \_ / \_ \_ |

***Contraception***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you sexually active? |  | Yes |  | No |
| Have you previously used any form of hormonal contraception before (pills/tablets, injections, coils/mirena/IUS/IUD)? |  | Yes |  | No |
| Do you use any contraception currently? |  | Yes |  | No |
|  | If **YES** please note the name: |  |
| Would you like to discuss forms of contraception at your appointment? |  | Yes |  | No |

***Medical History***

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| --- | --- | --- | --- | --- |
| Heart disease – heart attacks, ischaemic heart disease, heart failure, heart bypass, heart related surgeries |  | Yes |  | No |
| Diabetes (type 1 or type 2) – high blood sugar levels |  | Yes |  | No |
| Hypertension (High blood pressure) – if you are on blood pressure medication currently but your blood pressure is controlled please select YES |  | Yes |  | No |
| Osteoporosis – thin bones or fragile bones which can easily break |  | Yes |  | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been diagnosed with any cancer in the past? |  | Yes |  | No |
| Have any of your family members been diagnosed with cancer previously?  |  | Yes |  | No |
|  | If **YES** | Please note which types and which relative if known (e.g.) Breast, Endometrial/Uterine, Ovarian, Cervical, Other | **Relative (e.g. mother)** | **Cancer Type** |
|  | *If there is any history of breast cancer, if known, please state if it is oestrogen sensitive* |  |  |
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| Have you ever had a blood clot before? * Leg (Deep Vein Thrombosis
* Lung (Pulmonary Embolism)
 |  | Yes |  | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you suffer from migraines? |  | Yes |  | No |
|  | If **YES** | Has this been diagnosed by a doctor? |  | Yes |  | No |
|  | Do you take any prescribed medications for migraines? |  | Yes |  | No |

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| --- | --- | --- | --- | --- |
| Are you taking any medications not prescribed by the GP surgery?  |  | Yes |  | No |
|  | Please list the medications: |
| Have you had any previous adverse reactions or allergies to any medications, including hormone therapy? |  | Yes |  | No |
|  | Please list the medications and reactions: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you had any HRT treatment before? |  | Yes |  | No |
| Are you currently taking HRT? |  | Yes |  | No |

***Social***

|  |
| --- |
| Are you or have you ever been a smoker? |
|  | Never smoked |  |
|  | Ex-smoker |  |
|  | Current smoker |  |

|  |  |  |
| --- | --- | --- |
| How many units on average per week of alcohol do you drink? |  | units |

|  |  |  |
| --- | --- | --- |
| **Type of Drink (Measure)** | **% Alcohol (ABV)** | **Units** |
| Standard glass of wine (175 ml) | 12% | 2.1 |
| Large glass of wine (250 ml) | 12% | 3 |
| Bottle of wine (750 ml) | 12% | 9 |
| Pint of lower-strength beer or lager  | 3.6% | 2 |
| Pint of higher-strength beer or lager | 5.2% | 3 |
| Pint of cider  | 4.5% | 3 |
| Single measure of spirits (25ml) | 40% | 1 |

<https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator>

<https://www.drinkaware.co.uk/tools/unit-and-calorie-calculator>

|  |
| --- |
| How many minutes/hours per week do you exercise? |
|  | At moderate Intensity (you can still talk, but not sing) | \_\_\_\_ hours, \_\_\_\_ minutes |
|  | At vigorous Intensity (not be able to say more than a few words without pausing for breath) | \_\_\_\_ hours, \_\_\_\_ minutes |

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| --- |
| Do you have any specific concerns or questions related to the menopause, perimenopause, or HRT that you would like to discuss during your consultation? |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you interested in learning about alternative treatment options for managing menopause symptoms other than HRT? |  | Yes |  | No |

Once completed please return this form to the practice prior to your appointment. This can be handed in either as a printed copy or alternatively please email the practice e82084.harveyhousesurgery@nhs.net