**Please complete the below and submit by email to nelondonicb.wlmc@nhs.net in advance of your telephone/remote consultation; or bring with you to your face to face appointment**

|  |  |
| --- | --- |
| Name |   |
| Date of Birth  |   |

**MENOPAUSE SYMPTOM CHECKER**

As stated in NICE menopause guidance blood hormone tests are not indicated to diagnose menopause in a woman over 45 years of age experiencing menopause symptoms.

|  |  |  |  |
| --- | --- | --- | --- |
| **SYMPTOM**  | **YES**  | **NO**  | **DETAILS**  |
| ANXIETY  |   |   |   |
| LOW MOOD  |   |   |   |
| MOOD SWINGS  |   |   |   |
| IRRITABILITY  |   |   |   |
| TEARFUL  |   |   |   |
| LACK OF MOTIVATION  |   |   |   |
| LOSS OF JOY  |   |   |   |
| REDUCED CONFIDENCE  |   |   |   |
| BRAIN FOG  |   |   |   |
| POOR MEMORY  |   |   |   |
| POOR CONCENTRATION  |   |   |   |
| DIFFICULTY SLEEPING  |   |   |   |
| FATIGUE  |   |   |   |
| HEADACHES/MIGRAINES  |   |   |   |
| HEART PALPITATIONS  |   |   |   |
| HOT FLUSHES  |   |   |   |
| NIGHT SWEATS  |   |   |   |
| JOINT OR MUSCLE PAIN  |   |   |   |
| CHANGES TO PERIODS  |   |   |   |
| VAGINAL SYMPTOMS \*  |   |   |   |
| URINARY SYMPTOMS \*  |   |   |   |
| LOSS OF LIBIDO  |   |   |   |
| DRY/ITCHY SKIN  |   |   |   |
| DRY EYES/EARS/NAILS  |   |   |   |
| ORAL HEALTH CHANGES  |   |   |   |
| THINNING/DRYING HAIR  |   |   |   |
| WEIGHT GAIN  |   |   |   |
| FEELING DIZZY/FAINT  |   |   |   |
| TINNITUS  |   |   |   |
| RESTLESS LEGS  |   |   |   |
| INCREASED ALLERGIES  |   |   |   |
| DIGESTIVE ISSUES  |   |   |   |

**GENITOURINARY SYMPTOMS OF MENOPAUSE CHECKER**

As stated in NICE menopause guidance blood hormone tests are not indicated to diagnose menopause in a woman over 45 years of age experiencing menopause symptoms.

NICE states offer vaginal oestrogen to women with urogenital atrophy (including those on systemic HRT) and continue treatment for as long as needed to relieve symptoms.

Consider vaginal oestrogen for women with urogenital atrophy in whom systemic HRT is contraindicated, after seeking advice from a healthcare professional with expertise in menopause.

If vaginal oestrogen does not relieve symptoms of urogenital atrophy, consider increasing the dose after seeking advice from a healthcare professional with expertise in menopause.

NICE advises that doctors should explain to women with urogenital atrophy that:

* Symptoms often come back when treatment is stopped
* Adverse effects from vaginal oestrogen are very rare
* They should report unscheduled vaginal bleeding to their GP

**Please always see your GP for examination and advice before using any over the counter treatments.**

|  |  |  |  |
| --- | --- | --- | --- |
| **SYMPTOM**  | **YES**  | **NO**  | **DETAILS**  |
| VAGINAL/VULVAL DRYNESS  |   |   |   |
| VAGINAL/VULVAL SORENESS  |   |   |   |
| VAGINAL/VULVAL IRRITATION  |   |   |   |
| VAGINAL/VULVAL PAIN  |   |   |   |
| VAGINAL/VULVAL BURNING  |   |   |   |
| SKIN THINNING OR SPLITTING  |   |   |   |
| LABIA SHRINKING  |   |   |   |
| CLITORAL SHRINKING/PAIN  |   |   |   |
| WATERY DISCHARGE  |   |   |   |
| PAINFUL EPISIOTOMY SCAR  |   |   |   |
| ABNORMAL VAGINAL BLEEDING  |   |   |   |
| PAINFUL INTERCOURSE  |   |   |   |
| BLEEDING AFTER INTERCOURSE  |   |   |   |
| REPEATED URINARY INFECTIONS  |   |   |   |
| URGE URINARY INCONTINENCE  |   |   |   |
| STRESS INCONTINENCE  |   |   |   |
| PELVIC ORGAN PROLAPSE  |   |   |   |
| PAINFUL SMEAR TEST  |   |   |   |

**HRT ELEVATED RISK FACTOR CHECKER**

Some factors increase your risks from HRT. It is important to be aware of these when considering your personal risk from taking HRT. HRT is a safe and effective treatment option for most healthy women with symptoms

|  |  |  |  |
| --- | --- | --- | --- |
| **RISK FACTOR**  | **YES**  | **NO**  | **DETAILS**  |
| PREVIOUSLY HAD A BLOOD CLOT / DEEP VEIN THROMBOSIS (DVT) / PULMONARY EMBOLISM (PE) / HEART ATTACK / STROKE  |   |   |   |
| FAMILY HISTORY OF BLOOD CLOT / DEEP VEIN THROMBOSIS (DVT) / PULMONARY EMBOLISM (PE) OR AGED <60 A HEART ATTACK / STROKE  |   |   |   |
| DO YOU SMOKE?  |   |   |  HOW MANY A DAY? |
| WHAT IS YOUR WEIGHT? |   |   |   |
| WHAT IS YOUR HEIGHT? |  |  |  |
| PREVIOUSLY DIAGNOSED WITH BREAST CANCER |  |  |  |
| FAMILY HISTORY OF BREAST CANCER |  |  |  |
| PREVIOUSLY DIAGNOSED WITH UTERUS / WOUMB CANCER |   |   |   |
| FAMILY HISTORY OF UTERUS / WOUMB CANCER  |  |  |  |
| CAN YOU GIVE US A RECENT BLOOD PRESSURE? (YOU CAN HAVE THIS DONE AT YOUR PHARMACY |  |