**KENMORE MEDICAL CENTRE - MENOPAUSE/ HRT QUESTIONNAIRE**

Answering these questions ahead of your consultation will help the doctor to make an accurate assessment of your condition, needs and any important risk factors. There is a lot to cover, so answering this accurately helps us a lot. It will be scanned to your notes and read by the doctor just before or during the consultation, so please do not write anything here that requires an urgent response.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date form filled out \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height in cm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight in Kg \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoker? Y / N / past   
 - If yes/ past, how many per day and for how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many alcohol units do you typically drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
<https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator>

Exercise (type, and how often per week) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Score these symptoms please**. 0 = never / none 10 = very frequent / severe

|  |  |  |  |
| --- | --- | --- | --- |
| Daytime hot flushes |  | Urine frequency |  |
| Night sweats / flushes |  | Urine infections |  |
| Insomnia / poor sleep quality |  | I get up to pee \_\_\_ times/ night |  |
|  |  |  |  |
| Mood changes |  | Vaginal dryness |  |
| Anger / irritability |  | Vulval/ vaginal discomfort |  |
| Feeling low/ depressed |  | Vulval / vaginal itching |  |
| Tearfulness |  | Discomfort during sex |  |
| Anxiety / panic attacks |  |  |  |
| brain fog/ concentration problems |  | Lack of libido / lack interest in sex |  |
| Memory problems |  |  |  |
|  |  | Dry skin |  |
| Lack of energy |  | Itchy skin |  |
| Joint stiffness/ aches & pains |  | Hair loss |  |
|  |  |  |  |
| Headaches/ migraines |  | Symptoms change with cycles |  |

When was your most recent period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If within the last year, are your periods …? (circle) regular / irregular / erratic

Light / heavy / painful

Do you have any unexpected bleeding? Y / N Bleeding after sex? Y / N

Have you had a hysterectomy? Y / N If yes, when?   
Ovaries removed? Y / N

Have you ever been diagnosed with endometriosis? Y / N

Regarding contraception, do you use any of the following methods? (please indicate which)

female sterilisation [ ] partner had vasectomy [ ]  
condoms [ ] withdrawal method [ ]  
pill\* [ ] contraceptive implant in arm [ ]  
fertility cycle awareness [ ] intrauterine device\*\* [ ]  
other [ ] (state which) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

/ I do not require contraception because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Pill : if you currently take any hormonal contraceptives, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Intrauterine device : please indicate if you have a “coil” copper / Mirena / Other ?

Approximate date it was fitted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you tried before to treat the menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried HRT before? Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are currently on HRT, do you wish to continue or change type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not on HRT, do you wish to start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any preferences about type which could inform our discussion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal medical history/ Family medical history**

Please indicate if you or a family member have had any of the following?

|  |  |  |
| --- | --- | --- |
| Condition: | You | Family member (which relative and approx age) |
| Blood clot (DVT in leg / PE in lung) |  |  |
| Breast cancer |  |  |
| Stroke |  |  |
| Heart attack/ angina / heart bypass |  |  |
| Osteoporosis |  |  |
| Migraine |  | ----- not applicable ------------------------------------ |
| Liver disease |  | ----- not applicable ------------------------------------ |

Do you have any new or recent medical problems Kenmore do not yet know about? \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you up to date with cervical screening (smear tests) ? Y / N / unsure

Are you up to date with breast screening (mammograms) ? Y / N / unsure

PLEASE RETURN TO KENMORE RECEPTION ON PAPER OR BY EMAIL TO AS SOON AS YOU ARE ABLE MARKED “HRT / MENOPAUSE QUESTIONNAIRE” AHEAD OF YOUR CONSULTATION