Grace House, Scott Close, East Street, Newton Abbot, TQ12 1GJ
Tel: 01626 334411

Albany Surgery - 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) ____

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Dr J.M.Gaffney BMedSci MB BS MRCP MRCGP
Dr K.Lambert BSc MBChB MRCGP DFSRH DRCOG LOC SDI

Practice Manager: Ms Trudi Morrison
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Enquiriesatalbany.L83034@nhs.net

If you would like this letter or information in an alternative format (for example, large print or easy read) or if you need help with communicating with us (for example, because you use British Sign Language), please let us know.

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Please score these symptoms based on how severe you find them:

	Less severe			More severe
Daytime hot flushes	☐	☐	☐	☐
Night sweats / flushes	☐	☐	☐	☐
Insomnia / poor sleep quality	☐	☐	☐	☐
Mood changes	☐	☐	☐	☐
Anger/irritability	☐	☐	☐	☐
Feeling low / depressed	☐	☐	☐	☐
Tearfulness	☐	☐	☐	☐
Anxiety / panic attacks	☐	☐	☐	☐
Brain fog / concentration problems	☐	☐	☐	☐
Memory problems	☐	☐	☐	☐
Lack of energy	☐	☐	☐	☐
Joint stiffness / aches and pains	☐	☐	☐	☐
Headaches / migraines	☐	☐	☐	☐
Urine frequency	☐	☐	☐	☐
Urine infections	☐	☐	☐	☐
Getting up in the night to pee	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Vulval / vaginal discomfort	☐	☐	☐	☐
Vulval / vaginal itching	☐	☐	☐	☐
Discomfort during sex	☐	☐	☐	☐
Lack of libido / lack of interest in sex	☐	☐	☐	☐
Dry skin	☐	☐	☐	☐
Itchy skin	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐
Symptoms changing with your cycle	☐	☐	☐	☐

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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? ____

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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?________________________

____

____

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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 Albany Surgery 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 ALBANY SURGERY RECEPTION ON PAPER OR BY EMAIL (enquiriesatalbany.L83034@nhs.net) AS SOON AS YOU ARE ABLE MARKED "HRT / MENOPAUSE QUESTIONNAIRE" AHEAD OF YOUR CONSULTATION