

Westgate Surgery Menopause/HRT Questionnaire

Return the filled-out questionnaire to the surgery prior to your consultation.

Name:

DOB:

Date:

1) Blood pressure *Please obtain prior to your menopause appointment*:

2) Weight:

3) Height:

4) Do you smoke? If so, for how long and how many a day?

5) How much alcohol do you typically drink in a week?

6) Score these symptoms out of 10 (0 = no symptoms 10 = severe symptoms)

Symptoms	Score
Daytime sweats / flushes	
Night sweats / flushes	
Trouble sleeping	
Anxiety and/or panic attacks	
Irritability / Anger	
Mood changes	
Tearfulness and/or Depression	
Brain Fog/Loss of Concentration/Memory Loss	
Skin Dryness	
Formication (sensation of something crawling all over you)	
General aches and pains	
Poor / No Libido	
Vaginal Dryness/ Soreness / Pain when having intercourse	
Urine Infections / Urgency / Incontinence	
Hair Loss	
Migraines	
Headaches	

7) Are you using contraception? If yes, what are you using?

8) If you on HRT, how long have you been taking it?

If you do not take HRT, go to question 11

9) Do you experience any side effects from HRT?

10) Do you want to continue HRT?

Yes / No

11) Do you want to start HRT if you are not already on it?

Yes / No

12) Have you got a Mirena coil in place and if so, when and where was this fitted?

13) Have you had a hysterectomy? If so, was this a full or partial hysterectomy and do you still have smear tests?

14) Do you have a history of endometriosis?

15) When was your last period and what have your periods been like over the past year?

16) Do you have any unexpected spotting or bleeding?

17) Have you or a close family relative ever had breast cancer? If so, what age were you/they when it was first diagnosed?

18) Have you ever had any of these conditions?

Diagnosis	Yes / No	Date of Diagnosis/Instance(s)
Clots in the legs or lungs		
Cardiac Disease		
Stroke		
Heart Attack		
Angina		
Active Liver Disease		
Migraine		

19) a) Do you have a personal or family history of weak bones or Osteoporosis?

b) Have you broken any bones? If yes, when/what age?

20) Have you recently gained any new medical problems?

21) Are you up to date with your breast and cervical screening?

Please return to reception or email this form with the subject 'Menopause Form' to tccg.westgatepatient@nhs.net

Please note that this will not be read by a healthcare professional until your consultation, so please do not write anything on this form that requires an urgent response.

If you have something you must discuss with your GP urgently, please book a separate appointment.