**Hormone Replacement Therapy (HRT) Review Questionnaire**

**Questions:**

**1. Do you know the name of the hormone replacement therapy (HRT) that you want?**

* Yes
* No
* No, but I'd like the same one I was given last time

**2. What is the name of your HRT?**

**3. Have you started taking any new regular medications or health supplements recently?**

**(**Please include any over-the-counter supplements or medications)

* Yes
* No

**4. Which new medications or health supplements have you started taking since your last prescription?**

**5. Have you been diagnosed with any new health conditions since we last issued your HRT?**

(These could be any conditions but in particular: any breast or ovarian conditions, blood clots or a clotting disorder, cancer, heart disease, liver disease, migraines or diabetes)

* Yes
* No

**6. What new health conditions have you been diagnosed with since your last HRT issue?**

**7. Is HRT helping your symptoms?**

* Yes
* No

**8. How long have you been taking HRT?**

* Enter text

**9. Are you having any side effects or problems from your HRT?**

* Yes
* No

**10. Please describe any side effects or problems here**

**11. Do you have any vaginal dryness or discomfort?**

* Yes
* No

**12. Are you up to date with your breast screening (mammogram)?**

*(A mammogram is a type of X-ray that looks for breast cancer. You should be invited to have a mammogram every 3 years between the ages of 50 and 71 unless you have been told otherwise by a healthcare professional*.)

* Yes
* No
* I'm not sure

**13. Are you up to date with your cervical screening (smear test)?**

*(Unless you have been told otherwise by a healthcare professional, you should be invited to have a smear test every 3 years between the ages of 25 and 49, every 5 years from age 50 to 64 and then over 65 if one of your last 3 smear tests was abnormal.)*

* Yes
* No
* I'm not sure

**14. Do you have a family history of breast cancer?**

* Yes
* No

**15. Have you had any new or unexpected vaginal bleeding/spotting?**

(Such as after sex, between periods or after 12 months of not having a period)

* Yes
* No

**16. Have you had a hysterectomy?**

*(A hysterectomy is where you’ve had surgery to remove your womb [uterus].)*

* Yes
* No

**17. Are you currently using contraception?**

(Please note, HRT does not act as contraception)

* Yes
* No

**18. Which method of contraception do you use?**

**19. Do you require advice about contraception?**

* Yes
* No

**20. What is your smoking status?**

* Current Smoker
* Ex-smoker
* Never Smoked

**21. How much do you smoke? or How much did you smoke?**

* <1 cigarette or equivalent per day
* 1-9 cigarettes or equivalent per day
* 10-19 cigarettes or equivalent per day
* 20-39 cigarettes or equivalent per day
* 40+ cigarettes or equivalent per day

**22. How many years did you smoke for?**

**23. Are you able to provide a blood pressure reading?**

(As part of the review of your HRT we need an up-to-date blood pressure reading)

* Yes
* No





**24. Are you able to provide a weight and height reading?**

* Yes, both
* Weight Only
* Height Only
* No

**25. Please enter your weight in kilograms.**

**26. Please enter your height in metres.**

**27. Are you considering stopping your HRT?**

* Yes
* No

**28. Is there anything else regarding your HRT that you would like to change or discuss?**