

Hormone Replacement Therapy (HRT) Repeat Prescriptions

Please only fill in this questionnaire if you have been asked to by a member of the practice staff

**Please return this completed form via email to gram.skeneadministrator@nhs.scot**

1. Please confirm your full name and date of birth
2. Please indicate if you currently require a supply of HRT and which products you need:
3. Have you ever had a hysterectomy?

[ ]  Yes [ ]  No

1. Do you have a Mirena Coil fitted? If yes, when does it expire (can be used for up to 5 years)?

[ ]  Yes [ ]  No

1. What is your current weight (in kilograms) and height (in metres)?
2. What is your most recent blood pressure and when was this done?

If not had a BP check within 1 year please arrange an appointment to have this checked.

1. Have you been experiencing any side effects from your HRT that you would like to discuss?

[ ]  Yes [ ]  No

1. Do you currently have any persistent unexplained, or increased, vaginal bleeding that has not been reviewed?

[ ]  Yes [ ]  No

1. Have you ever had any blood clots (deep vein thrombosis or pulmonary embolism)?

[ ]  Yes [ ]  No

1. Have you ever had breast cancer or endometrial cancer?

[ ]  Yes [ ]  No

1. Are you up to date with your breast screening (mammograms)?

[ ]  Yes [ ]  No

1. Have you ever had a heart attack or stroke?

[ ]  Yes [ ]  No

1. Do you have a family history of any of the following?

[ ]  Bloods clots in the lungs or legs

[ ]  Breast or endometrial cancer

[ ]  Stroke

[ ]  Heart attack

1. Are you currently using contraception?

[ ]  Yes [ ]  No (if you have answered no, please select one of the below options if applicable)

 - [ ]  I am over 50 and my last period was more than 1 year ago

 - [ ]  I am under 50 and my last period was more than 2 years ago

 - [ ]  I am over 55

1. Would you like to discuss contraception options?

[ ]  Yes [ ]  No

1. Are you taking any weight loss medication, e.g. Mounjaro, Wegovy etc.?

(Sometimes these medications can affect HRT and will need to be reviewed)

[ ]  Yes [ ]  No

1. Do you smoke? If yes, how many cigarettes do you smoker per day on average?

[ ]  Yes [ ]  Never-smoker [ ]  Ex-smoker

1. Do you wish to have a discussion with a member of the clinical team regarding changes to your current HRT?

[ ]  Yes [ ]  No

If you ever experience any of the following symptoms whilst taking HRT, please consult the practice immediately:

* Painful swelling in your leg
* Chest pains, difficulty breathing or coughing up blood
* Unexplained and unexpected vaginal bleeding
* Breast lump, nipple changes or persistent breast pain
* Weakness or numbness in an arm or leg
* Sudden issues with your speech or sight