Updated April 2025

Bayview Medical Practice

Hormone Replacement Therapy (HRT) Questionnaire

In order to provide HRT safely, we need to ask you a number of questions.
All patients who are on HRT need to have a review three months after starting and every 12 months thereafter.
PLEASE COMPLETE THIS FORM AND RETURN IT TO THE PRACTICE AT LEAST TWO WEEKS BEFORE YOUR NEXT PRESCRIPTION IS DUE

Patient Name: ***Date of Birth:*** ***Age:***

Today's date: ***Contact Number:***

What is the name of your HRT? _____

1. Please record an updated blood pressure _____/_____
   (this can be checked at the chemist, at the treatment room or by using an at home monitor)
2. Are you a smoker? ☐Yes ☐No
   a) If yes, how many cigarettes/how much tobacco do you smoke per day? _____cigarettes
   _____oz tobacco
3. If you are an ex-smoker, do you vape? ☐Yes ☐No ☐N/A
4. What is your weight? (kg or st) _____kg
   ___st ____lb
5. What is your height? (cm or ft) _____cm
   ___ft ____in
6. When was your last period? _____
7. Have you had a hysterectomy? ☐Yes ☐No
8. Do you have a Mirena coil fitted? ☐Yes ☐No
9. If yes, When was it fitted? _____
10. Have you experienced any persistent unexpected bleeding, or increased bleeding? ☐Yes ☐No
11. Are you up-to-date with your mammograms? (every three years) ☐Yes ☐No
12. Have you ever had any blood clots? (e.g., deep vein thrombosis or pulmonary embolism) ☐Yes ☐No

13. Have you ever had a heart attack or stroke? ☐Yes ☐No

14. Have you ever had breast or endometrial cancer? ☐Yes ☐No

15. Have you ever had liver or gallbladder disease? ☐Yes ☐No

16. Do you have any family history of:
    ☐ Blood clots ☐ Heart attack ☐ Stroke
    ☐ Breast cancer ☐ Endometrial cancer ☐None

17. Are you currently using contraception? ☐Yes ☐No
    a) If No, please select if any of the following are applicable:
    No – I am over 50 and my last period was over one year ago ☐Yes
    No – I am under 50 and my last period was over two years ago ☐Yes
    No – I am over 55 ☐Yes

18. How often do you have a drink containing alcohol?
    ☐ Never ☐ monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

I have the following questions that I would like to raise about my HRT:

Thank you for completing this questionnaire.
Please hand this page back to reception and a clinician will review your answers.
If there are any problems with reissuing your prescription, we will contact you.

If you are experiencing any of the following, please ring your GP immediately:

- *Painful swelling of leg*
- *Weakness or numbness of an arm or leg*
- *Sudden problems with your speech or sight*
- *Difficulty breathing*
- *Breast lump, persistent breast pain, or nipple changes*
- *Pains in your chest, especially if it hurts to breathe in*
- *Coughing up blood*
- *Unexpected vaginal bleeding*
- *Persistent irregular bleeding*
- *Abdominal pain, discomfort or bloating*
- *Unintended weight loss*