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| --- | --- | --- | --- | --- |
| This form is for patients who simply require a further prescription of their HRT medication. If you have any concerns **DO NOT** use this form but book an appointment with a Nurse. Please complete the required information and we will issue a prescription to your nominated Chemist. It will take **48hrs** to generate your prescription. **There is a slightly higher risk of developing breast cancer, endometrial cancer, and ovarian cancer, having heart disease or stroke and developing a blood clot in the leg or lung in patients taking hormone replacement medication. This risk is minimal, but patients should be made aware of this.**  **PLEASE FILL IN ALL FIELDS WITH AN ASRERIX (\*)** | | | | |
| **Personal Details** | **Patient to complete using blood pressure monitor at reception :** | | | |
| Title/Full name\*: | **Blood pressure reading\*:** | **Date of last natural period\*:** | | |
| Date of Birth\*: |
| Mobile Number(s): | **Weight (in Kgs)\*:** | **Height (in cm)\*:** | | |
| BMI | Name of HRT medication (please specify if tablets, gel or patches)\*: | | | |
| **MEDICAL HISTORY** | | | | |
| Please circle your answers. | | | | |
| 1. Have you had any problems or concerns with your HRT? \*   If yes please state: | | | Yes | No |
| 1. Have you had any undiagnosed vaginal bleeding?\* | | | Yes | No |
| 1. Do you suffer from migraines?\* | | | Yes | No |
| 1. Do you have a family or personal history of DVT or pulmonary embolism?\* | | | Yes | No |
| 1. Have you had any problems or concerns with your HRT, including side effects?\*   If yes please state: | | | Yes | No |
| 1. Are you on any other hormone therapy or contraception ie: Mirena?\* | | | Yes | No |
| 1. Do you currently smoke?\* | | | Yes | No |
| **\*\*If you answer yes to any of the above questions- PLEASE BOOK AN APPOINTMENT WITH A GP\*\*** | | |  |  |
| **OTHER INFORMATION:** | | | | |
| 1. Do you examine your breasts?\* | | | Yes | No |
| 1. Have you had a hysterectomy (removal of uterus)?\* | | | Yes | No |
| Signature of Patient: | | | Date: <Today's date> | |
| ***For office use:***  Has patient had a hysterectomy (removal of uterus) and on progesterone preparation?  Has not had a hysterectomy and on an ESTROGEN ONLY PREPATION? (Patient should be on a combined preparation if NOT had a hysterectomy).  Is on a continuous combined regimen and date of last period is less than 12 months?  Is on a cyclical regimen and late of last period is over 12 months and/or 54 years and over?  BMI> 35?  BP >140 systolic or >90 diastolic?  **If yes to any of the above then needs to be reviewed with AA**  **Send appropriate information if patient has said no to questions 8?** | | | ***For office use:***  Signed: …………………………  Assessing Technician  Date: ……………………… | |

**ANNUAL HRT CHECK**