**Annual HRT CHECK**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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\*:** | **Weight (in Kgs) \*:** | **Height (in cm) \*:** | | |
| Date of Birth\*: |
| Mobile Number(s): | 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. Are suffering from new migraines **since starting HRT\*** | | | | Yes | No |
| 1. Do you have a 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? If so, please state length of time it has been inserted: | | | | Yes | No |
| 1. Do you currently smoke? \* | | | | Yes | No |
| 1. Do you examine your breasts? | | | | Yes | No |
| 1. Have you had a hysterectomy (removal of uterus)? \* | | | | Yes | No |
| 1. Please answer this question if you are under 54 years: Was the date of your last **NATURAL** period more than 1 year? | | | | Yes | No |
| 1. Are you on any Weight Loss Injections (Ozempic/Mounjaro) | | | | Yes | No |
| 1. Are you getting Weight Loss Injections through private prescriber | | | | Yes | No |
| Signature of Patient: | | | | Date: | |

|  |  |
| --- | --- |
| ***For office use:***   * Has patient had a hysterectomy (removal of uterus) and on progesterone preparation? Inform pharmacists. * Has not had a hysterectomy and on an ESTROGEN ONLY PREPATION? (Patient should be on a combined preparation if NOT had a hysterectomy). Inform pharmacists. * Is on a continuous combined regimen and date of last period is less than 12 months? Inform pharmacists. * Is on a cyclical regimen and late of last period is over 12 months and/or 54 years and over? Inform pharmacist. * BMI> 35 and on tablets inform pharmacist. * BP >140 systolic or >90 diastolic? Issue prescription but ask for home blood pressure readings for 7 days. * BP > 160 systolic or > 95 diastolic? Do not issue and inform AA/usual GP. * If on tablets and suffers from migraines? Inform pharmacists. * If answers yes to 1,2,4,5,6 inform AA/usual GP. * If answered yes to smoking (8) and on oral HRT- Inform pharmacists, otherwise can issue. * If on Mirena should be changed every 5 years * If on Mirena should not be on progesterone, inform AA. * If patient on testosterone, please ensure annual blood tests set up. * If patient on Weight loss Injections (Ozempic/Mounjaro), and on Oral Progesterone, please offer alternative route or give high dose progesterone as per new guidelines. https://www.pcwhs.co.uk/\_userfiles/pages/files/resources/glp1\_contraception\_hrt\_article.pdf * Please make an entry on patient’s records for weight loss injections | ***For office use:***  Signed: ………………  Assessing Technician  Date: ………………… |