HRT / Contraception review

Name _____ **Date** _____

D.O.B _____

Height [ ] cm

Weight [ ] kg

BP [ ] systolic [ ] diastolic *If either number ≥ 140 / 90 please complete home blood pressure monitoring*

Smoker (circle) No Yes [ ] cigarettes / day

I am taking (circle) HRT Hormonal Contraception

If taking contraception

Name of contraception ……

Are you happy with your current contraception and wish to continue? YES NO

Are you interested in LARC*? YES NO

**Longer acting reversible contraception (coil, implant, injection)*

If on HRT

Name of HRT ……

Are you happy with your current HRT and wish to continue? YES NO

Would you like to consider reducing or stopping your HRT? YES NO

Have you had a hysterectomy (removal of your uterus)? YES NO

Last menstrual period (approx.) [ ]

All HRT and contraception patients

Are you up to date with your smears / mammograms? (if applicable) YES NO

Are you experiencing any troublesome side effects you would like to discuss? YES NO

Any of the following? (circle if applicable)

migraine *blood clots (DVT / PE)* *breast changes or lumps*

unexpected vaginal bleeding or spotting *heart attack or stroke* *bleeding during or after sex*

PRESCRIPTION REQUIRED **YES** **NO**

PLEASE CALL RECEPTION TO BOOK AN APPOINTMENT IF YOU HAVE ANY CONCERNS OR WISH TO DISCUSS FURTHER