

ANNUAL REVIEW FOR WOMEN PRESCRIBED HRT

NAME: _____ Date Of Birth: _____

Telephone number which you are happy for us to contact you on: _____

Date you need your next supply of medication: _____

You have recently requested a repeat prescription of your HRT. Your annual review is now due. If you have no problems with your HRT it may not be necessary for you to see the doctor or nurse and instead you may just complete this form fully and return it to us within the next two weeks. We do need to know your **height, weight and blood pressure**. You can check these without an appointment at the surgery or at home.

If you would rather see the nurse for your annual review, please make an appointment and bring the completed form to the appointment with you.

Once we have processed the information on this form, we will decide whether you can pick up a prescription for a further 6 month supply of medication or whether the nurse wishes to see you before prescription can be issued. Occasionally the nurse will need to speak to you before prescription is issued, it is therefore essential that we have a telephone number on which you are happy for us to contact you. If you have not heard from us in a week you can pick up your next prescription.

When did you start using HRT? _____

NAME OF TREATMENT YOU ARE TAKING: _____

Have you had a hysterectomy? Yes No

Do you have a Mirena coil fitted? Yes No

What date did you have coil fitted? _____

Do you think you are getting any side effects from your HRT Yes No

If yes, please give details _____

Are you immobile (i.e. In a wheelchair)? Yes No

Do you suffer from migraines? Yes No

If yes, do your migraines provoke loss of vision / numbness / weakness or speech problems?

Do you have any allergies/allergies to medication (If yes, please specify) Yes No

Have you ever had a blood clot in your leg or lung? Yes No

Has a close relative ever had a blood clot in the leg or lung? Yes No

Have you had any history of breast cancer? Yes No

Have you any history of ovarian cancer? Yes No

Have you ever had a stroke or mini stroke (TIA)? Yes No

Have you had a mammogram within the last 3 years? Yes No

Do you have any Family History of breast cancer? Yes No

Do you have any Family History of ovarian cancer? Yes No

Do you have any family history of Heart disease in a close relative under the age of 55 (man) or 65 (woman)? Yes No

Do you smoke? Ex-smoker Date stopped: _____
 Never Smoked
 Smoker _____ per day
 Vaping

Please note – we advise all smokers that they should stop smoking. Smoking does increase the risks of circulatory problems. If you would like to stop smoking please ask a receptionist to sign post you to the stop smoking service. Or visit www.nhs.uk **Quit smoking or download the free NHS Quit smoking app**

Your height _____ (cm)

Your weight _____ (kg)

Please staple Blood Pressure printout here

We usually prescribe 6 months of treatment. If you prefer fewer packs, please state the number required here: _____

Your signature: _____ Date: _____

Surgery use:

BMI _____ DATA INPUT COMPLETED BY _____ DATE _____

All items to be prescribed generically unless specified.

- Issue 6m prescription
- Issue 1m prescription, book appointment for routine review
- Urgent review
- HRT contraindicated