**Name:**……………………………………………………………………………………………………..

**D.O.B:**………………………… **NHS number if known:**………………………………….

**Medication requesting/taking:**……………………………………………………..

**If using an MIRENA coil how long has this been in?**.........................

**Blood pressure readings- taken in last month:**………………………………

**Weight in the last month:**…………………………….

**Smoking status:**  - Smoker □ **Please confirm how many a day you**

**smoke:**………………

- Never-smoked □

- Ex-smoker □

**Have you ever had or developed in the last 12 months:–**

* Blood clot- DVT or PE □
* Cancer of the breast or endometrium □
* Stroke □
* Heart Attack or Angina □
* Migraine □
* Active liver disease □

•You may be experiencing a combination of physical, mental and sexual health symptoms. If you are struggling to cope or feel your medication is not helping you, please contact us, to book a review with one of our HRT clinical team members

•If you are taking HRT that induces a monthly bleed (Cyclical HRT), it is advised you move to continuous HRT (daily tablet that does not lead to a monthly bleed) after 4 years.

* Please call to book an appointment with a member of the HRT clinical team to discuss this change, if you have been taking a cyclical HRT pill for over 4 years.

**Stop taking your mediation if you develop abnormal vaginal bleeding, have a DVT or PE or develop Cancer or Liver disease, until you have discussed your case with our HRT clinical team.**

**PLEASE COMPLETE THIS FORM AND EITHER EMAIL IT TO THE SURGERY…………………………………..OR HAND IT IN AT RECEPTION WHEN YOU NEXT PUT IN A REQUEST FOR MORE MEDICATION.**