Dr Francesca Irvine
MBChB DRCOG MRCGP DFSRH

Dr Catherine Johnston
MBChB

Edenkiln Surgery
12 Dumbrock Road
Strathblane
G63 9EG

HRT REVIEW

Personal Details

First Name

Last Name

Date of Birth (dd/mm/yyyy)

Height (ft. in)

Weight (st. lbs)

Preferred Contact Number

Email Address

Clinical Questions

Are you happy with your current HRT?	☐ Yes ☐ No
Would you like a GP appointment to discuss further?	☐ Yes ☐ No
Blood pressure reading (eg 120/70):	____ / ____
Do you smoke?	☐ Yes ☐ No
Do you still need contraception?	☐ Yes ☐ No

Are you suffering any menopausal symptoms? ☐ Yes ☐ No

If yes, please give details:

Have you had a hysterectomy? ☐ Yes ☐ No

Do you have a coil in? ☐ Yes ☐ No

Have you ever had a blood clot, heart disease, stroke, cancer, migraine or major illness? ☐ Yes ☐ No

If yes, please give details:

Regarding your own health, have there been any changes in the last 12 months? ☐ Yes ☐ No

If yes, please give details:

Are there any comments you would like to add? ☐ Yes ☐ No

Are you taking any medication not prescribed by your GP (including weight loss medication)? ☐ Yes ☐ No

If yes, please give details:

Scan the QR code to read about the full risks and benefits of taking HRT before completing this form.

Do you understand and have you read about all the risks and benefits of taking HRT? ☐ Yes ☐ No

Privacy Notice

This form collects your name, date of birth, email address, and other personal and medical details. This information is used to confirm that you are registered with the practice, to allow the practice team to contact you, and to update your medical records. Please read our full Privacy Notice for details on how we protect and manage your submitted data.

☐ I consent to the practice collecting and storing my data on this form.

Signature

Date (dd/mm/yyyy)