

## **Menopause Consult Acknowledgement and Questionnaire**

By signing this consent to begin/continue hormone replacement therapy, I understand that hormone replacement therapy has risks and possible side effects and that this information may change over time. You may need to wean off or stop HRT all-together if you are deemed to be at an unsafe level of risk.

### ***Absolute Contraindications (Hormones will not be prescribed or refilled if you have):***

- Known, suspected or history of breast cancer
- Known or suspected estrogen-dependent neoplasia
- Undiagnosed abnormal uterine bleeding or post-menopausal bleeding
- History of thromboembolic disease
- Liver disease
- Gallbladder disease
- Known hypersensitivity to ingredients of estrogen preparation
- Known or suspected pregnancy
- HRT is not started over the age of 60 or it is more than 10 years after you stopped having periods. If you are already using HRT, the provider **may** provide refills if no contraindications develop between visits.

### ***Relative Contraindications (Hormones may not be prescribed or refilled if you have):***

- Smoking
- Migraine with aura
- Endometriosis
- Severe hypertriglyceridemia
- Increased risk for breast cancer

### ***Some Benefits of HRT include:***

- Decrease hot flashes and night sweats
- Improve vaginal dryness
- Helps to protect against bone loss and subsequent fractures
- May reduce the risk of colon cancer

### ***Some Risks of HRT include:***

- Can increase risk of uterine cancer.
- Small increased risk of heart attack that research suggests may be related factors such as age, other medical conditions, and age at HRT start.
- Small increased risk of stroke and deep vein thrombosis (DVT). HRT that is NOT taken by mouth (patches, gels, sprays, rings) have less risk of causing DVT than those taken by mouth.
- Potential to increase risk of breast cancer if taken for prolonged periods of time or combined with a progestin
- Small increased risk of gallbladder disease

### ***Some Side Effects of HRT include:***

- Vaginal spotting or abnormal bleeding
- Fluid retention
- Breast soreness

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Signature

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Date

## Screening Questions

What is your age?

What is your race/ethnicity?

If Hispanic – Born in the US or Born outside of the US

If Asian American – Chinese Filipino, Hawaiian, Pacific Islander, Japanese or Other

What was your age at first menstruation?

When was your last menstrual period? (MMDDYYYY)

What was your age when gave birth to your first child?

Do you have a history of? (Circle yes or no)

- Yes or No – Heart disease (palpitations, heart attacks, murmurs, chest pain, arrhythmia)
- Yes or No - Stroke, mini-strokes, or transient ischemic attack
- Yes or No - High blood pressure
- Yes or No - History of breast cancer, ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS)
- Yes or No - Endometrial/Uterine cancer
- Yes or No - Vaginal bleeding
- Yes or No – Any blood clotting disorders
- Yes or No – Protein S deficiency
- Yes or No – May-Thurner Syndrome
- Yes or No - Liver disease or Elevated Liver Function Tests
- Yes or No - Gallbladder disease
- Yes or No - Allergy or reaction to ingredients of estrogen preparation
- Yes or No - Known or suspected pregnancy
- Yes or No – Smoking
  - o If you are a former smoker, what year did you quit?
- Yes or No – Migraines with aura
- Yes or No - Endometriosis
- Yes or No - Severe hypertriglyceridemia (elevated triglycerides)
- Yes or No - Previous radiation therapy to the chest for treatment of Hodgkin lymphoma
- Yes or No - Mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome
- Yes or No - Breast biopsy
  - o If yes – how many?
  - o Yes or No - Did the biopsy show atypical hyperplasia?
- Yes or No - Breast cancer in your family
  - o If yes – Are they 1<sup>st</sup> degree relatives (Mother, Sister or Daughter)?