



Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

# FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry or wrinkled skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80



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# HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient office visit fee

\$ 0

Female hormone pellet insertion fee

\$ 400.00

We accept the following forms of payment:

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

# HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, [www.hhs.gov](http://www.hhs.gov).

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

# FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred contact number: \_\_\_\_\_

May we send messages via text regarding appts to your cell?  Yes  No

Email address: \_\_\_\_\_ May we contact you via email?  Yes  No

In case of emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_

Primary care physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Address / City / State / Zip

Marital status (check one):  Married  Divorced  Widow  Living with partner  Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_

## Social:

- |  |    |  |   |
|--|----|--|---|
| <input type="checkbox"/> I am sexually active.       | OR | <input type="checkbox"/> I want to be sexually active.                                   | <input type="checkbox"/> I do not want to be sexually active. |
| <input type="checkbox"/> I have completed my family. | OR | <input type="checkbox"/> I have NOT completed my family.                                 |   |
| <input type="checkbox"/> My sex life has suffered.   | OR | <input type="checkbox"/> I have not been able to have an orgasm or it is very difficult. |   |

## Habits:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> I smoke cigarettes or cigars _____ per day. | <input type="checkbox"/> I use e-cigarettes _____ a day.                  | <input type="checkbox"/> I use caffeine _____ a day. |
| <input type="checkbox"/> I drink alcoholic beverages _____ per week. | <input type="checkbox"/> I drink more than 10 alcoholic beverages a week. |  |



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

# FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

## Drug allergies

Drug allergies: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Have you ever had any issues with local anesthesia?  Yes  No Do you have a latex allergy?  Yes  No

Medications currently taking: \_\_\_\_\_

Current hormone replacement?  Yes  No If yes, what? \_\_\_\_\_

Past hormone replacement therapy: \_\_\_\_\_

## Family history:

Heart disease  Diabetes  Osteoporosis  Alzheimer's/dementia  Breast cancer  Other \_\_\_\_\_

## Pertinent medical/surgical history:

- |  |   |
|--|---|
| <input type="checkbox"/> Breast cancer           | <input type="checkbox"/> Fibrocystic breast or breast pain    |
| <input type="checkbox"/> Uterine cancer          | <input type="checkbox"/> Uterine fibroids                     |
| <input type="checkbox"/> Ovarian cancer          | <input type="checkbox"/> Irregular or heavy periods           |
| <input type="checkbox"/> Polycystic ovaries/PCOS | <input type="checkbox"/> Menstrual migraines                  |
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Hysterectomy with removal of ovaries |
| <input type="checkbox"/> Excess facial/body hair | <input type="checkbox"/> Partial hysterectomy (uterus only)   |
| <input type="checkbox"/> Infertility             | <input type="checkbox"/> Oophorectomy removal of ovaries only |
| <input type="checkbox"/> Endometriosis           |   |
| <input type="checkbox"/> Epilepsy or seizures    |   |

## Birth control method:

- Menopause
- Hysterectomy
- Tubal ligation
- Birth control pills
- Vasectomy
- IUD
- Infertility
- Other \_\_\_\_\_



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# FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

## Medical history:

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure or hypertension                       | <input type="checkbox"/> Stroke and/or heart attack        |
| <input type="checkbox"/> Heart disease   | <input type="checkbox"/> HIV or any type of hepatitis      |
| <input type="checkbox"/> Atrial fibrillation or other arrhythmia                   | <input type="checkbox"/> Hemochromatosis                   |
| <input type="checkbox"/> Blood clot and/or a pulmonary embolism                    | <input type="checkbox"/> Psychiatric disorder              |
| <input type="checkbox"/> Depression/anxiety  | <input type="checkbox"/> Thyroid disease                   |
| <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Thyroid disease                   |
| <input type="checkbox"/> Hair thinning   | <input type="checkbox"/> Lupus or other autoimmune disease |
| <input type="checkbox"/> Sleep apnea   | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> High cholesterol  |  |