



Address and Contact Information

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	Never (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.

Table with 2 columns: Fee Name and Amount. Rows include New Patient Office Visit Fee (\$220), Female Hormone Pellet Insertion Fee (\$480), and Male Hormone Pellet Insertion Fee (\$730).

We accept the following forms of payment: cash, credit cards, HSA. If pelleting is chosen, \$100 will be credited to your account

Patient Signature: [] Date: []



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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

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.

Print Name:

Signature:

Date:



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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 appointments 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: []
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.
[] []

Social:
[] I am sexually active. OR [] I want to be sexually active. [] I do not want to be sexually active
[] I have completed my family. OR [] I have NOT completed my family.
[] My sex life has suffered. OR [] I have not been able to have an orgasm or it is very difficult.

Habits:
[] I smoke cigarettes or cigars [] per day. [] I use e-cigarettes [] a day [] I use caffeine [] a day.
[] I drink alcoholic beverages [] per week. [] I drink more than 10 alcoholic beverages a week.



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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Female Medical History

Any known drug allergies: []

Have you ever had any issues with local anesthesia? [] Yes [] No

If yes, please explain: [] Do you have a latex allergy? [] Yes [] No

Medications Currently Taking: []

Current Hormone Replacement Therapy: []

Past Hormone Replacement Therapy: []

Nutritional/Vitamin Supplements: []

Surgeries, list all and when: []

Last menstrual period (estimate year if unknown): []

Other Pertinent Information: []

Preventative Medical Care:

- Medical/GYN exam in the last year. Mammogram in the last 12 months. Bone density in the last 12 months. Pelvic ultrasound in the last 12 months.

Pertinent Medical/Surgical History:

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

Birth Control Method:

- Menopause, Hysterectomy, Tubal ligation, Birth control pills, Vasectomy, IUD, Infertility, Other []



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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical Illnesses:

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Any form of hepatitis or HIV | <input type="checkbox"/> Chronic liver disease
(hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Lupus or other autoimmune
disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Frequent blood donation or
history of anemia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Hair thinning | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Stroke and/or heart attack | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Blood clot, DVT and/or
a pulmonary embolism | | <input type="checkbox"/> Cancer (type): <input type="text"/> |
| <input type="checkbox"/> Heart arrhythmia or atrial
fibrillation | | Year: <input type="text"/> |



This page for information only and a form will be reviewed after actual insertion

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POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages... Do not take tub baths or get into a hot tub or swimming pool for 3-4 days... No heavy lifting or major exercises... The sodium bicarbonate in the anesthetic may cause the site to swell... The insertion site may be uncomfortable for up to 2 to 3 weeks... You may experience bruising, swelling, and/or redness... You may notice some pinkish or bloody discoloration... If you experience bleeding from the incision, apply firm pressure for 5 minutes... Please call if you have any bleeding not relieved with pressure... Please call if you have any pus coming out of the insertion site...

REMINDERS:

- Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion... Most women will need re-insertion of their pellets 3-4 months after their initial insertion... Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

[]
[]
[]

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

Print Name: []
Signature: []
Date: []



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WHAT MIGHT OCCUR AFTER A PELLETT INSERTION (FEMALE)

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- INFECTION: Is possible with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.
• PELLET EXTRUSION: Pellet extrusion is uncommon and occurs in < 5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.
• ITCHING or REDNESS: Itching or redness in the area of the incision and pellet placement is common. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to contact the office
• FLUID RETENTION/WEIGHT GAIN: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.
• SWELLING of the HANDS & FEET: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.
• UTERINE SPOTTING/BLEEDING/IRREGULAR PERIODS: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.
• MOOD SWINGS/IRRITABILITY: These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

- HAIR LOSS: Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. Workup for other causes may also be needed.
• FACIAL BREAKOUT: Some pimples may arise if the testosterone levels are either too low or rise rapidly. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.
• HAIR GROWTH: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or "peach fuzz" often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.
• BREAST TENDERNESS or SWELLING: This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is Iodine Plus if this occurs.
• ELEVATED RED CELL COUNT (most common in men): Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased.
• HIGH or LOW HORMONES LEVELS: The majority of the time, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a "boost" (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.

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