NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____
(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a personal history of? **Check all that apply.**

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

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type:_____ Year: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

FOR OFFICE USE ONLY

CHART ID:_____ **DOB:**_____ **APPT DATE:**_____

All About Health
www.allabouthealth.com

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.

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 healthcare 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 the 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: _____

All About Health®

Consent for Treatment

I hereby state that I have honestly and without exaggeration or omission, completed the attached "New Patient Forms." I also state that I have disclosed all information that might reasonably be considered relevant to decisions made by Physicians regarding my care. I have disclosed all past illnesses, particularly those involving any form of cancer. I also state that I have disclosed all medications that I am taking at the present time and will inform Physician of any medications that may be prescribed now and in the future by other physicians. I also state that I have disclosed the past and present use of any substances including prescribed or nonprescription drugs, alcohol, steroids, vitamins, and dietary supplements. I hereby hold harmless and waive any claim or defense against Physician for any harm or injury I sustained because of my failure to fully disclose all relevant facts about my physical and medical condition to Physician. I waive any claim or defense against Physician for any I sustain because of my failure to comply with the method of treatment and dosage schedule prescribed by Physician. I agree to immediately cease any medical treatment prescribed by Physician in the event of any adverse response or side effect arising from prescribed treatment and to provide immediate notice of such adverse response or side effect to Physician via phone or office visit. I agree to comply with the prescribed instructions for use of all medications prescribed by Physician. I agree all medications are for my personal use and are not to be used by anyone other than myself.

I understand that the practice of medicine is not an exact science and that all diagnosis and treatment may involve risks of injury, including but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of the diagnostic testing analysis of test results, examination of medical history, or treatment by Physician.

I acknowledge and accept that Physicians may not physically see me and will use lab testing, "New Patient Forms" , a physical done by my primary care physician and provided by me to Physician, and telephonic conversations as the primary basis for diagnosis and treatment of any condition(s) I may have.

I certify that I have read and understand the questions in these forms; I acknowledge that I will have the opportunity to discuss my health history with my doctor. I will not hold my doctor or any other member of his/ her staff responsible for any errors or omissions that I have made in the completion of these forms.

Print Name: _____

Signature: _____

Date: _____

All About Health®

Consent for Intramuscular (IM) Injection Therapy

Your healthcare practitioner feels you may benefit from receiving Intramuscular (IM) vitamin injections. You have been diagnosed with or have an increased risk of having and/ or developing nutritional deficiencies, fatigue, weakness, muscular aches, or general tension/ stress which may be associated with your specific condition. The use of this therapy as it relates to your condition is considered an alternative treatment and has not been evaluated or approved by the Food and Drug Administered (FDA).

You have the right, as a patient, to be informed about your condition and the recommended alternative or non-conventional procedures to be used so that you may make an informed decision to undergo this procedure. This disclosure is meant to inform you of the benefits and any potential risks that could occur.

Your practitioner may order a variety of vitamin injections, alone or in combination. A full list of ingredients and exact dosages is available at your request.

Potential practitioners may order a variety of vitamin injections: Some individuals, based on clinical criteria, may have a nutritional deficiency, fatigue, or the need for physiological enhancement due to poor diet, disease, illness, infection, increased metabolism, or the need to alleviate stress or muscular tension. Administration of nutrient nutrient and vitamin IM injections can achieve more efficient delivery and achieve higher levels of absorption than taking oral supplements and greatly reduce the risk of gastrointestinal side effects that frequently occur with oral consumption. A standard vitamin IM injection includes vitamins, minerals, and amino acids such as Vitamin B12, Vitamin B6, Vitamin B Complex, Chromium, Adenosine, Magnesium, GABA; with potential additions/ subtractions per healthcare practitioner recommendation.

Potential Risks of IM Vitamin Injections: As with any injection, discomfort at the needle insertion site, allergic reaction, redness, irritation, bruising, or localized infection may occur. On rare occasions, some individuals may experience dizziness, lightheadedness or nausea immediately following an injection; this is a common nervous system response and passes quickly.

Contraindications of (IM) Vitamin Injections: May include bleeding disorders, pregnancy, chemotherapy, cancer history and certain allergies and are evaluated on an individual basis. Patient Statement: I agree to comply with any testing that may include laboratory or other diagnostic testing requested by my healthcare provider any adverse reaction or problem that may be related to my therapy or if I suspect I am pregnant. I understand the potential risks and benefits of the therapy and they have been explained to me, and all my questions have been adequately answered. I understand that I have not been guaranteed or promised any specific benefit to the administration of therapy.

I attest that I have read this form, or had it read to me and I agree to the treatment recommended and I will not undergo any treatments that I do not fully understand.

Print Name: _____

Signature: _____

Date: _____

FEMALE TESTOSTERONE AND/OR ESTRADIOL PELLET INSERTION CONSENT FORM

Bio-identical hormone pellets are concentrated hormones biologically identical to the hormones you make in your own body. Estrogen, progesterone and testosterone are derived from the female ovaries (primarily) and adrenal glands (secondarily) prior to menopause.

Testosterone is a hormone produced by the ovaries and adrenal glands in women. In the medical research, testosterone supplementation in women has been shown to improve fatigue, exercise intolerance, muscle tone, libido, weight, decrease depression, anxiety and mood disorders and other conditions.

Though laboratory assays can support a diagnosis of testosterone deficiency, they should not be used to exclude it as there are multiple problems in the measurement of testosterone (ex. dietary intake, sexual activity, sample storage variables, circadian variations). Greater reliance on the clinical features and consideration of symptoms is suggested as an appropriate tool in treating women with testosterone therapy. There is no generally accepted "normal" level of testosterone for women. It is reasonable to prescribe testosterone to a woman who has symptoms of low and to expect total testosterone values that are supraphysiologic after treatment.

All testosterone use in women is considered "off-label". Off-label use refers to the use of any medication for something other than its FDA approval. Many medications prescribed in the US are prescribed for off-label use. The off-label use of testosterone therapy has not been evaluated by the FDA and any claims of benefit are purely educated opinions that come from consideration of various medical research studies. It is reasonable to expect a supraphysiologic testosterone laboratory value after pellet therapy is initiated.

Hormone pellet production is highly FDA regulated; however, the pellet insertion procedure is not an FDA approved procedure for hormonal replacement.

Goals for treatment with this medication will be discussed at each appointment. If goals are met, then maintenance doses will be discussed. If the treatment is not as effective as anticipated, it might be discontinued; at that time, alternative therapies will be discussed. You are welcome to seek a second opinion or a specialist consultation.

The safety of hormone therapy during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy. Continuous exposure to testosterone during pregnancy may cause adverse effects in the fetus.

My birth control method is (please check):

__Abstinence __Birth Control Pill __Hysterectomy __IUD __Menopause __Tubal Ligation
__Vasectomy __Other

SIDE EFFECTS: Side effects of subcutaneous hormone pellets will be managed clinically and individually. There have been no reported *irreversible* side effects of subcutaneous pellet therapy noted in the literature.

Potential side effects of pellet insertion may include, but not limited to: Surgical risks are the same as for any minor medical procedure. Bleeding, bruising, swelling, and pain; extrusion of pellets; infection or abscess formation; seroma formation; scarring at insertion site; keloid scar.

Potential side effects of the hormones may include, but are not limited to:

Estradiol Related: Dysfunctional uterine bleeding; growth of estrogen dependent tumors and breast tenderness (estradiol).

Testosterone Related: Hyper-sexuality (overactive libido) increase one's hemoglobin and hematocrit (erythrocytosis), acne, increase in body/facial hair growth, abnormal menstrual cycles, hair loss/thinning and virilization, voice changes or abnormal growth of the female genitals (testosterone).

17-beta estradiol has not been shown in any clinical study to date to increase breast, uterine or ovarian cancer risk; however if a patient has an undiagnosed estrogen/hormone dependent cancer a possible risk of accelerated growth may occur. For this reason mammograms, according to the current clinical guidelines, are required as a baseline prior to the initiation of hormone therapy. Every patient has a right to refuse diagnostic mammogram. ***I understand if I refuse I will be required to sign a mammogram waiver before I am to receive hormone therapy. I understand if I have a uterus and am on estradiol therapy I must take oral micronized progesterone (prescription) daily for protection against uterine cancer.***

CONSENT FOR TREATMENT: I have been informed that I may experience any of the complications related to this procedure. Periodic adjustments are required to fine tune the treatment with this type of medication. Periodic blood tests are necessary to determine if the dose needs to be adjusted. I understand that hormone therapies are available in other forms including creams and oral medications. I understand that I am consenting to testosterone therapy for off label use of my symptoms. I understand the hormone pellet procedure is not FDA approved.

AFTERCARE: I agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of hormone and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of hormone therapy. I accept these risks and benefits and I consent to the insertion of hormone pellets with a dosage regime discussed thoroughly by my hormone pellet provider.
I have read and understand this document in its entirety and have been given the opportunity to ask questions concerning my care. I consent to subcutaneous hormone pellet insertion. **This consent is ongoing for this and all future subcutaneous hormone pellet insertions.**

Patient Name	**Patient Signature**	**Date**

References:

Carruthers, M. (2008). The paradox dividing testosterone deficiency symptoms and androgen assays: a closer look at the cellular and molecular mechanisms of androgen action. The journal of sexual medicine, 5(4), 998-1012.

Carruthers, M. (2008). The paradox dividing testosterone deficiency symptoms and androgen assays: a closer look at the cellular and molecular mechanisms of androgen action. The journal of sexual medicine, 5(4), 998-1012.

Bachmann, G., Bancroft, J., Braunstein, G., Burger, H., Davis, S., Dennerstein, L., ... & Traish, A. (2002). Female androgen insufficiency: the Princeton consensus statement on definition, classification, and assessment. Fertility and sterility, 77(4), 660-665.

Shufelt, C. L., & Braunstein, G. D. (2009). Safety of testosterone use in women. Maturitas, 63(1), 63-66.

Panay, N., & Fenton, A. (2009). The role of testosterone in women.

Maclaran, K., & Panay, N. (2012). The safety of postmenopausal testosterone therapy. Women's Health, 8(3), 263-275.

WHAT MIGHT OCCUR (FOR FEMALES ONLY)

Patient Name:_____ **DOB:**_____

A significant hormonal transition will occur in the first 3-6 weeks after beginning your BHRT regime. Therefore, certain changes might develop that can be bothersome.

FLUID RETENTION: 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, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

UTERINE SPOTTING/BLEEDING: 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. They will disappear when enough hormones are in your system.

FACIAL BREAKOUT: Some pimples may arise if the body is very deficient in testosterone. 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 THINNING: Is VERY rare and usually occurs in patients who over-convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in these rare cases.

HAIR GROWTH: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

I acknowledge that I have received a copy and understand the instructions on this form.

_____	_____	_____
Name (Print Legibly)	**Signature**	**Date**

Female Post Insertion Instructions

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 3 to 4 hours. It **must** be removed as soon as it gets wet. You may replace it with a bandage to catch any anesthetic that may ooze out. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**. If the tape or steri-strip comes off you may replace it with a band-aid.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **4 days**, this includes running, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days. This is normal.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding (not oozing) or pus coming out of the insertion site that is not relieved by pressure.

REMINDERS

- **New patients - VERY Important!**
  - Please go for your post-insertion blood work 4 weeks after your initial pellet insertion.
  - Please schedule a lab review appointment 5 weeks after your initial pellet insertion so we can review your post-insertion lab results. There is no charge for this office visit.
- On average, females need pellet insertions every **4 months** after their initial insertion.
- Please call to make an appointment for a re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion and not a consultation.

Print Name_____**DOB**_____**Signature**_____**Date:**_____