FEMALE PATIENT QUESTIONNAIRE AND MEDICAL HISTORY

Name: _____ Today's Date:_____

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____

Email Address: _____

In Case of Emergency Contact Name: _____

Relationship: _____ Contact Number: ( )_____

Primary Physician: _____ Phone: ( )_____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status (check one): ( )Married ( )Divorced ( )Widow ( )Single ( )Living w/ partner

Spouse's Name: _____

SOCIAL HABITS: (check all that apply)

( ) I am sexually active

( ) I want to be sexually active

( ) I have completed my family

( ) My sex has suffered

( ) I haven't been able to have an orgasm

( ) I smoke _____ cigarettes a day

( ) I drink _____ alcoholic beverages _____ times a week

( ) I drink caffeine _____ times a day

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MEDICAL HISTORY

Drug Allergies: _____

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 test 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

Birth Control Method (Must choose one):

( ) Menopause

( ) Hysterectomy

( ) Tubal Ligation

( ) Oral birth control pills

( ) Vasectomy (sexual partner)

( ) Other: _____

Medical Illnesses:

( ) High blood pressure

( ) Heart bypass

( ) High cholesterol

( ) Heart disease

( ) Polycystic Ovarian Syndrome

( ) Stroke and/or heart attack

( ) Blood clot or a pulmonary embolism

( ) Arrhythmia

( ) Any form of Hepatitis or HIV

( ) Lupus or other auto immune disease

( ) Fibromyalgia

( ) Trouble urinating

( ) Chronic liver disease

( ) Diabetes

( ) Thyroid disease

( ) Arthritis

( ) Depression/Anxiety

( ) Psychiatric disorder

( ) Cancer (type): _____

FEMALE TESTOSTERONE AND/OR ESTRADIOL PELLET CONSENT FORM

Name: _____ Today's Date: _____

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations of menstrual cycles.

Bio-identical hormone pellets are made from soy and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYN's in the U.S. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

MY BIRTH CONTROL METHOD IS: (PLEASE CHOOSE ONE)
Abstinence Birth Control Pill Hysterectomy IUD Menopause Tubal Ligation Vasectomy Other

Consent for treatment: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. Surgical risks are the same as for any minor medical procedure and are included in the list of overall risk below:

Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive libido); lack on effect; breast tenderness and swelling especially in the first 3 weeks (estrogen only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability. Decreased weight, Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that most insurance companies do not consider pellet therapy to be a covered benefit and it is my responsibility to submit a claim for possible reimbursement.

_____	_____	_____
Print name	**Signature**	**Today's Date**

MAMMOGRAM WAIVER FOR PELLET THERAPY

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My treating provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

I do not have a mammogram for the following reasons:

( ) My decision not to have one

( ) Unable to provide the report at this time

( ) My doctor's decision not to have one

Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The treating provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol. _____ (patient initials)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my treating provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of current cancer or new cancer. I hereby release and agree to hold harmless Dr. Donovtiz, Treating Provider (Christine LaComb, RN, MSN, FNP-C), BioTE Medical, LLC., and any of their BioTE Medical physicians, nurses, officers, directors, employees and agents from any liability, claims, demands, and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask any questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____	_____	_____
Print name	**Signature**	**Today's Date**

PAP AND TRANSVAGINAL U/S WAIVER FOR PELLET THERAPY

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy.

( ) For today's appointment I DO NOT have a pap smear for the follow reason:

- ( ) My decision not to have one
- ( ) Unable to provide report at this time
- ( ) My doctor's decision not to have one

( ) For today's appointment I DO NOT have a transvaginal ultrasound for the following reason:

- ( ) My decision not to have one
- ( ) Unable to provide report at this time
- ( ) My doctor's decision not to have one

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The treating provider has discussed the importance and necessity of a pap smear and/or transvaginal ultrasound since I receive testosterone and/or estradiol. _____ (patient initials)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my treating provider.

I understand that pap smear and/or transvaginal u/s are the best single method for detection of early breast cancer. I understand that my refusal to submit this test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer) that may be sustained by me in connection with my decision to not have a pap smear/transvaginal u/s and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of current cancer or new cancer. I hereby release and agree to hold harmless Dr. Donovtiz, Treating Provider (Christine LaComb, RN, MSN, FNP-C), BioTE Medical, LLC., and any of their BioTE Medical physicians, nurses, officers, directors, employees and agents from any liability, claims, demands, and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask any questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____	_____	_____
Print name	**Signature**	**Today's Date**

LaComb Health & Wellness

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, _____date_____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.