my Medical Makeover

Female Hormone Patient Information Form

Name: _____

DOB: _____/_____/_____

What are you seeing the doctor for today?

_____

_____

_____

When did you first notice the symptoms?

_____

_____

_____

Female Personal History:

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages/abortions: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear?

☐ Yes ☐ No Describe: _____

Are you currently sexually active? ☐ Yes ☐ No

What type of contraception are you currently using?

_____

Is your sex drive similar as it was 5 years ago?

☐ Yes ☐ No Describe: _____

Do you have pain with intercourse? ☐ Yes ☐ No

Have you had any sexually transmitted diseases?

☐ Yes ☐ No Describe: _____

Are you HIV positive? ☐ Yes ☐ No

If yes, when did this occur? _____

Treatment? _____

Have you ever had cervical, uterine or ovarian cancer?

☐ Yes ☐ No Describe: _____

Treatment? _____

Do you have any breast lumps, tenderness or discharge?

☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, when? _____ Was it normal? _____

Do you have or have you ever had breast cancer? _____

If yes, are you currently undergoing treatment? _____

☐ Lumpectomy ☐ Mastectomy ☐ Chemotherapy ☐ Radiation Therapy ☐ Other _____

Have you ever had any form of cancer?

☐ Yes ☐ No Type: _____

Have you had hormone levels taken in the past?

☐ Yes ☐ No When? _____

Are you using any form of Hormone Therapy?

☐ No ☐ Pills ☐ Cream ☐ Patches ☐ Pellets

☐ Other: _____

Experienced any weight gain or loss in last 1-2 years?

☐ Yes ☐ No Describe: _____

Do you have any problems with water retention, swelling or bloating? ☐ Yes ☐ No

Any trouble with urinary incontinence? ☐Yes ☐No

Do you have osteopenia/osteoporosis? ☐ Yes ☐ No

Have you had blood clots in your legs or lungs?

☐ Yes ☐ No Describe: _____

Do you suffer from hair loss? ☐ Yes ☐ No

Do you suffer from acne? ☐ Yes ☐ No

Menstrual History

If you no longer have periods, please check reason:

☐ Natural ☐ Hysterectomy ☐ Ablation

☐ Menopause What age? _____

Do you have a uterus? ☐ Yes ☐ No

Do you have fibroids of the uterus? ☐ Yes ☐ No

First day of last period? _____/_____/_____

Approximate length of period? (# of days) _____

Are your periods regular? ☐ Yes ☐ No

# of days between start of periods? _____

Any changes in flow of period? ☐ Yes ☐ No

If yes, describe: _____

Do you suffer cramps during period? ☐ Yes ☐ No

If yes, describe: _____

Does bleeding occur between cycles? ☐ Yes ☐ No

Do you have PMS symptoms? ☐ Yes ☐ No

If yes, describe: _____

Have you had any abnormal bleeding in the past year?

☐ Yes ☐ No

If yes, describe: _____

Medical History:

Do you have or ever had any of the following?			
	Yes	No	History of
Anemia/Bleeding disorder:	☐	☐	☐
Anesthesia complications:	☐	☐	☐
Describe:			
Arthritis:	☐	☐	☐
Type:			
Asthma:	☐	☐	☐
Blood clots:	☐	☐	☐
Crohn's/Colitis	☐	☐	☐
Diabetes:	☐	☐	☐
Emphysema/Bronchitis:	☐	☐	☐
GERD (Reflux)	☐	☐	☐
Heart attack or stroke:	☐	☐	☐
Heart disease:	☐	☐	☐

Medical History (continued)			
	Yes	No	History of
Hepatitis:	☐	☐	☐
Type:			
High Cholesterol:	☐	☐	☐
Hypertension:	☐	☐	☐
IBS	☐	☐	☐
Kidney disease:	☐	☐	☐
Liver disease:	☐	☐	☐
Lung disease:	☐	☐	☐
Lupus/Scleroderma:	☐	☐	☐
Major accidents:	☐	☐	☐
Describe:			
Polyps- Colon	☐	☐	☐
Psychiatric disorder:	☐	☐	☐
Describe:			
Thyroid problems:	☐	☐	☐
Type: ☐low function	☐overactive	☐goiter	☐hashimoto
Varicose veins:	☐	☐	☐
Other:			

Do you suffer from any of the following?

Anxiety	☐ Yes ☐ No
Decrease in sexual desire	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Difficulty concentrating	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No
Foggy thinking	☐ Yes ☐ No
Hot flashes	☐ Yes ☐ No
Migraines	☐ Yes ☐ No
Mood swings	☐ Yes ☐ No
Muscle and/or joint pain	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No
Poor memory	☐ Yes ☐ No
Sleeping problems	☐ Yes ☐ No
Vaginal dryness	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No

Reviewed by: _____

Date: _____

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Financial Acknowledgement and Insurance Information
Female Hormone Pellet Insertion

Bio-identical hormone replacement pellet therapy is typically not recognized by insurance carriers as a reimbursable procedure for females. Hormone replacement therapy is considered investigational and does not meet medical criteria for treating females including those with symptoms related to menopause and reduced libido. Due to this, we collect all fees for hormone replacement at the time of service. We **do not** file claims for these services to insurance carriers on the patient's behalf. If you intend to file the claim to your insurance company, please provide your primary insurance carrier information. This will help us in responding to your carrier on your behalf if additional information is requested.

I, _____, hereby certify that I am eligible for
(Patient Name)

insurance coverage with _____.
(Name of Insurance Carrier)

Subscriber Name: _____ DOB: _____

Policy contract # or ID #: _____

Group #: _____ Effective Date: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

I understand that My Medical Makeover does NOT file insertion claims to my insurance carrier on my behalf. I agree to pay in full for all insertion related expenses on the day of service. <u>I also understand that payment on the day of insertion is to be paid with cash or credit card prior to insertion of pellets.</u>

_____ _____
Patient Name (Printed) **Date of Birth**

_____ _____
Patient Signature **Today's Date**