Welcome to Allura Skin, Laser, & Wellness Clinic!

Your appointment is scheduled on:

DAY & DATE: _____

CHECK IN TIME: _____

APPT. TIME: _____

PROVIDER: ☐ Dr. Rebecca de la Torre ☐ Dr. Suzy Saenz ☐ Cathleen Robinson, PA ☐ Terra Bookout, PA

LOCATION: ☐ 1615 Foxtrail Drive, Suite 190, Loveland, CO

☐ 2032 Lowe Street; Suite 103; Fort Collins, CO

PHONE NUMBER: 970-223-0193

FAX NUMBER: 970-669-5348

EMAIL: hormonereplacement@alluraclinic.com

Please arrive 30 minutes prior to your appointment as there is additional paperwork to complete.

If you do arrive 15 minutes late, there is a chance you will only have time for the *consultation* with the Provider and/or the pellet(s) insertion may have to be rescheduled.

If a cancellation is necessary, please call at least 48 hours in advance.

COMPLETE ALL THE ATTACHED NEW PATIENT FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT or YOU MAY FAX, MAIL, or EMAIL THE PATIENT FORMS:

- ☐ Health History
- ☐ General Consent Form
- ☐ Fees for pellet therapy
- ☐ FAQ sheet
- ☐ HIPPA sheet
- ☐ Medical Release form
- ☐ Insurance Disclaimer
- ☐ Lab Disclaimer

As always, please feel free to call us if you have any questions.

We appreciate the privilege of serving your health care needs.

We look forward to seeing you soon.

ALLURA
skin, laser & wellness clinic

Bio-Identical Hormone Fees

(Fees as of JANUARY 2015)

We have found that insurance companies vary tremendously in reimbursing patients for bio-identical hormones using pellets. Additionally, our providers are not Medicare or HMO providers. For these reasons, we do not guarantee that your insurance company will reimburse you for your treatment.

You will be responsible for payment in full at the time of your procedure.

Upon request, we can mail paperwork that you may submit to your insurance company to file for reimbursement.

Consult fee:	$100 (consult only; no insertion)
Initial Insertion Fee: (Initial consult fee, insertion fee And pellet fee)	Average female fee is $340-$370. Average male fee is $580-$700.
Booster Insertion Fee: (5-7 weeks after the initial insertion)	Average female fee is $185. Average male fee is $285.
Female Maintenance Insertion Fee: (every 3-4 months):	Average female insertion fee is $270.
Male Maintenance Insertion Fee: (every 4-6 months)	Male insertion fee range is $480-$600.

Actual fee is dependent on the number of pellets inserted

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Hormone Replacement Therapy FAQ

- **What is Pellet Hormone Therapy?**
  We are more aware of receiving hormone therapy via oral tabs, creams, injections, or patches. For many of us, those methods of treatments have not helped us as much as we hoped. Pellet therapy, which has been present for decades, is inserting a bio-identical hormone pellet in the buttocks area. Once the pellet is inserted, a steady, low dose of natural hormone flows directly into the blood stream and increases the amount of hormone whenever the body needs it, such as in exercise or stress. This method gives the body the ability to control the release of the hormones just as it did when the ovaries or testicles were working normally. The *SottoPelle method* insures an individualized dose for each patient based on their body's individual needs.

- **What are Bio-identical Pellets made from?**
  The pellets are compounded according to the highest industry standards, using the best quality botanical ingredients available. Derived from a natural plant source of soy, yam and other natural plants, they are specifically formulated to replicate human estradiol and testosterone hormones. Nothing synthetic, just pure and natural biologically-identical hormones.

- **How long do the pellets typically last?**
  3-5 months for women and 4-6 months for men.

- **How do I receive my treatment?**
  Each hormone pellet is the size of a grain of rice and inserted painlessly under the skin in the buttocks area. A mild, local anesthetic is used to numb the skin where the insertion will take place. The insertion takes less than five minutes. Repeat treatments involve a brief visit with one of our skilled providers 3-4 times per year for women and 2-3 times per year for men. That is it!

- **What are the side effects or complications?**
  Women: Side effects may include breast tenderness for 7-10 days after insertion, mild spotting or light breakthrough bleeding and slight weight gain from muscle growth or water retention. These side effects can be decreased or reversed by adjusting the subsequent estradiol doses. Facial hair growth, mild thinning of hair and acne are side effects that can occur but are reversible by adjusting the subsequent testosterone doses.
  Men: Transient breast tenderness if the estradiol level increases more than expected with increased levels of Testosterone. Transient aggressiveness and irritability can also occur. Symptoms can be eliminated by reducing the subsequent testosterone dose or by treating with medication.

- **How much does Hormone Therapy Cost?**

  One time Consult fee: $100

  Initial insertion: Average female fee is $240-$270.
  Average male fee is $480-$600.
  Actual cost depends on the number of pellets inserted.

  Booster Insertion:
  (5-7 weeks after the initial insertion)
  Average female fee is $185.
  Average male fee is $285.
  Actual cost depends on the number of pellets inserted.

  Female Maintenance Insertion Fee:
  (every 3-4 months)
  Average female insertion fee is $270.

  Male Maintenance Insertion Fee:
  (every 4-6 months)
  Male insertion fee ranges between $480 and $600.

  We accept the following forms of payment:
  MasterCard, Visa, Discover, American Express, Care Credit, Health Savings Account (HSA) debit card, Personal Checks and Cash.

- **Do we accept insurance?**
  We do not accept insurance. All payments are required in full at the time of your appointment. Upon request, our office can mail an insurance form to you that you may submit to your insurance.
  DUE TO CHANGES IN INSURANCE REGULATIONS, WE NO LONGER SUBMIT CLAIMS FOR OUR PATIENTS.

- **What do I need to do to get started?**
  The **first step** is to call for an appointment for an initial consult and treatment.
  The **second step** is getting your labs drawn. Your lab results are crucial in determining your hormone deficiencies and then calculating the perfect dose and plan for you.
  Please be aware that lab results can take at least 7-14 days for us to receive.

- **Where are the labs drawn?**
  Labs can be drawn at your Primary Care Physician's office, hospital or lab facility of your choice.

- **Medicare Patient?**
  Our providers are not Medicare or HMO providers and are considered "out of network" physicians. You will be responsible for payment of your labs if the labs are not ordered from your primary care physician or specialist.

  To prevent unnecessary costs, our staff will send you a letter specifying the labs required for your appointment. This letter needs to be taken to your physician's office so that the labs can be ordered by your physician. By having your physician order the labs, your insurance should cover the lab fees.

- **No insurance or have an insurance plan with a large deductible?**
  For patients who do not have insurance, have insurance plans with large deductibles or their insurance declines coverage of the labs, **Allura** has contracted reduced lab fees with **LABCORP**. The lab fees must first be prepaid at Allura before the labs will be drawn at a LABCORP facility. LABCORP fees are comparable to the "patient assisted programs" described below. Our staff will assist you through this process.

  Additionally, **Longmont United Hospital and Banner Health have "*patient assisted programs*"**. "Patient Assisted programs" mean that you do not need a physician's order to have the labs drawn. You are able to order your own labs. These programs are available to patients who do not have insurance or have insurance plans with large deductibles. We can assist you by letting you know which labs need to be ordered for your appointment. The lab results are mailed directly to you. We do not receive a copy of the labs so please bring the results to your appointment.

- **What time should I arrive for my initial consultation?**
  Please arrive 30 minutes prior to your appointment. There is additional paperwork to complete prior to seeing the provider.

- **What are the benefits of doing hormone replacement therapy?**
  Hormone replacement therapy using pellets is beneficial to the human body and provides relief with:
  - **enhancement** of libido or increased sexual desire
  - **increase** in lean body mass and decrease in body fat
  - **greater capacity** for getting in shape
  - **anti-inflammatory affects** that reduce achiness of joints and muscle soreness
  - **increased energy levels**
  - **consistency in mood:** reduction in feelings of anger, nervousness and irritability
  - **relief** from anxiety and depression
  - **increased** vitality, focus, mental clarity and concentration
  - **improved** memory
  - **increase** sense of overall well being
  - **protection** from heart disease

- **Questions?**
  We are well staffed with a knowledgeable hormone team that can answer your questions or address any concerns that may arise while you are on pellet therapy. Please call our office at 970-223-0193 and ask to speak to our medical assistant, or email us at hormonereplacement@alluraclinic.com. Our medical assistant can answer most of your concerns but can contact one of our providers if needed.

You will find that pellet therapy is going to help you feel the best you have felt in a long time!

Female Estradiol & Testosterone Hormone
General Consent Form

General: Bio-identical hormone pellets are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone, which are made in the ovaries and adrenal glands. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger, without the monthly fluctuations of menstrual cycles.

Birth Control: ***Patient who are pre-menopausal are advised to continue using reliable birth control while receiving pellet hormone replacement therapy. Testosterone is listed as category X (will cause birth defects) and cannot be given to pregnant women.***

Benefits and Risks: I have been told I may have testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. The potential benefits of testosterone include a possible increase in my bone density, short term memory, protection against Alzheimer's and Parkinson's, increase in energy, libido, and sense of well-being. Testosterone decrease the frequency and severity of my headaches.

I have also been told that I may have estradiol pellet(s) inserted under my skin to also achieve a steady state of estradiol in my body. The potential benefits of estradiol include possible elimination of my mood swings, anxiety, irritability, cardiovascular protection, sleep disturbance, and protection from developing colon cancer, improvement of bone density and brain dysfunction.

Side effects can occur with pellet therapy. In some cases, the body will convert a higher percentage of testosterone to Dihydrotestosterone (DHT). DHT can cause acne or hair loss. Both can be corrected by adjusting the testosterone dose in the subsequent visit and/or prescribing medication that blocks the conversion to DHT.

The estradiol can aggravate fibroids or polyps, if they exist, and cause bleeding. I understand that if I have a uterus and receive estradiol, I will be required to take oral progesterone. Progesterone will offset estrogen's effect on the uterus lining and reduce my risk of bleeding or having a period. ***I also understand that it is not unusual to have breakthrough bleeding or spotting though it is a nuisance.*** I am to call my provider at ALLURA if breakthrough bleeding or spotting occurs.

Side effects that can occur but are transient or reversible may include:

- bleeding, infection and pain at the insertion site;
- lack of effect (from lack of absorption);
- breast tenderness and swelling especially in the first three weeks (estrogen effect);
- increase in hair growth on the face;
- transient water retention
- change in voice;
- clitoral enlargement

Potential side effects that are to be aware of include:

- increased growth of estrogen dependent tumors;
- birth defects in babies exposed to testosterone during their gestation;
- growth of liver tumors, if they are already present;

Pellet Insertion:

Sterile surgical placement of Estradiol and Testosterone pellets for under the skin is performed by a designated medical professional (Physician or Physician Assistant). Insertion of pellets requires the use of local anesthesia consisting of 1% lidocaine and epinephrine which is deemed necessary by the treating providers. Lidocaine can cause a brief stinging or burning sensation for a few seconds Epinephrine can cause brief shakiness, jitteriness, and heart racing.

Insertion Risks:

I understand that the insertion site may be sore for 2-3 weeks. My level of activity must be minimized for 2-3 days following the pellet insertion. As with any form of implant, there is always the risk of infection, bruising, or bleeding at the insertion site. Certain medications and supplements can thin the blood which can increase bleeding or bruising at the insertion site. We have found that women who return to a *vigorous* exercise program 2-3 days after insertion experience soreness or discomfort for 2-3 weeks. We have also found that infection at the insertion site and/or pellet extrusion can occur when the insertion site is continually rubbed or irritated by the waistline or belt. Instructions on the post-pellet insertion sheet must be followed to avoid such risks and/or minimize discomfort.

Medications:

I understand that progesterone will be prescribed if I have an intact uterus. Progesterone is to prevent the uterus lining from thickening. A diuretic may be prescribed if swelling or breast tenderness should occur after my initial insertion.

Labs and Appointments:

I understand that lab work is required prior to my first appointment and if not available, then the appointment for appointment will be postponed.
I also understand that labs are necessary for management of my hormone replacement, especially during the initial 6-8 months of therapy. Labs are required prior to the initial insertion, 4 weeks after the initial insertion, and 2 weeks prior to each maintenance insertion.
Once my hormone levels are stable, labs will be drawn on a yearly basis. Additional labs may be drawn when deemed necessary by the treating provider or when requested by you, the patient.
I understand that I am responsible for any lab charges that may not be covered by my insurance company.

I understand that a booster insertion is required 5-6 weeks after the first insertion. Routine or maintenance appointments are every 3-4 months.

Charges: Office visit charges include an insertion fee, provider fee and hormone pellet fees. The pellet fee varies and depends on the number of pellets I may receive. The precise amount is to be determined by the treating medical provider.

Payments: I understand payment is due in full at the time of services. **I understand that the clinic does not accept insurance.**

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 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. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure any condition that I may have.

Patient Name: _____

Signature: _____

Date of Birth: _____ Today's Date: _____

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HIPPA-Health Insurance Portability and Accountability Act

YOUR RIGHTS: Under the Federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION: You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records. I understand this is not in relation to requesting medical records for me for another physician. There is a separate form that is filled out for that request which I can obtain by contacting ALLURA SKIN, LASER, & WELLNESS CLINIC.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES: With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

Person(s)/organizations authorized to receive and use this information:

- ☐ Insurance Company (Please write the name of your insurance company and policy number):

  _____

- ☐ Pharmacy (release of name, date of birth, allergies only)

- ☐ Significant Other or Family Member: _____

OTHER USES AND DISCLOSURE: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:
For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence).

To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.

For health oversight activities (for example-audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions).

For law enforcement purposes (for example-reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons).
To avert a serious threat to health or safety under certain circumstances.
For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
For compliance with worker's compensation claims.

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Release of Medical Records Form

FEMALE-1

Please complete:

To: _____ _____
Your Doctor's Name Clinic Name

_____ _____ _____
City State Zip

_____ _____
Phone Number Fax Number

I, _____, authorize _____
Patient Name Your Doctor's Name

to release any individually identifiable health information related to me **FROM THE PREVIOUS TWO YEARS**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply) to **Allura Skin, Laser, & Wellness Clinic**:

- Estradiol, Total Testosterone, Progesterone and FSH
- Mammogram Report
- Pelvic Ultrasound
- Chemistry Panel
- Thyroid Panel
- Pap Report
- Bone Density
- CBC

FAX TO: **Allura Skin, Laser, & Wellness Clinic**
Dr. Rebecca de la Torre

2032 Lowe Street; Suite 103	1615 Foxtrail Drive, Ste. 190
Fort Collins, CO 80525	Loveland, CO 80538
Fax: 970-669-5348	Phone: 970-223-0193

_____ _____
Print Name Date of Birth

_____ _____
Patient Signature Date

INSURANCE DISCLAIMER

Unfortunately, insurance companies do not recognize Bio-identical hormone replacement therapy as "necessary medicine". Bio-Identical hormone therapy is considered "alternative medicine".

Additionally, the physicians and physician assistants at Allura Skin, Laser, & Wellness Clinic are not associated with any insurance companies, including MEDICARE.

This means that your insurance is not obligated to pay for your blood work, consultations, insertions or pellets.

However, we do encourage you to submit a claim for your visit as we have found, on occasion, patients have been reimbursed a small portion of their treatment fees.

Upon request, we can mail paperwork that you may submit to your insurance company to file for reimbursement.

For patients who have access to **Health Savings Account (HSA)**, you may pay for your treatment with that credit or debit card. We encourage you to consider a Health Savings Account if this option is offered by your employer.

We require payment at time of service and accept **MasterCard, Visa, American Express, Discover, Care Credit, personal checks and cash.**

By signing below, I understand the information given above.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

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LABORATORY DISCLAIMER

Unfortunately, Insurance companies do not recognize Bio-identical hormone replacement therapy as "necessary medicine". Bio-Identical hormone therapy is considered "alternative medicine".

Additionally, the physicians and physician assistants at Allura Skin, Laser, & Wellness Clinic are not associated with any insurance companies, including MEDICARE.

This means that **your insurance is not obligated to pay** for your blood work ordered by our providers. However, labs will be covered if ordered by **your** primary care physician.

Medicare Patients:

Three to four weeks prior to each appointment, you will receive a letter addressed to your physician requesting that specific labs be drawn. Please take this letter to your physician or clinic. **By having your physician order the labs, your insurance should cover the cost of the labs.**

Should your physician **refuse to order** the necessary labs, please contact our office and ask to speak to a member of the bio-identical hormone staff.

Medicare Patients or Patients who do not have health insurance or have health plans with large deductibles:

Allura has contracted reduced lab fees with **LABCORP**. The lab fees must be prepaid at Allura before the labs will be drawn at a LABCORP facility. We accept credit card payments over the phone.

Longmont United and **Horizon** offer "patient assisted programs" which are discounted lab fees for patients who do not have health insurance or have health plans with large deductibles. The programs allow you to have labs drawn without a physician's order. We can assist you by letting you know which labs need to be ordered. At the lab site, you will complete an order form that selecting the labs to be drawn. As this is a patient driven program, the lab will mail the results directly to you. We are not given a copy of your results so please bring your lab results with you to your appointment.

In order to have lab results available at your appointment, we recommend that labs are drawn 10-14 days prior to your appointment.

By signing below, I understand the information given above.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

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FEMALE HEALTH HISTORY INFORMATION

To help us serve you better, please take a moment to complete this information.

Today's Date: _____

Last Name: _____ First Name: _____

MI: _____ Nick Name: _____

Date of Birth: _____ Age: _____

Street Address: _____

P.O. Box Number: _____

City: _____ State: _____ Zip Code: _____

Email address **(Please Print Legibly):**

_____

YOUR EMAIL ADDRESS IS OUR PREFERRED MEANS OF CONTACTING YOU

Home Number: _____ Cell Number: _____

Employer: _____ Work Number: _____

Occupation: _____

Preferred phone number for contact: □ Home □ Cell □ Work

May we send you an email for appointment reminder information? □ Yes □ No
…for medical or additional scheduling information? □ Yes □ No
…for notifying you of our monthly specials? □ Yes □ No
May we send you regular mail? □ Yes □ No

Marital Status:
□ MARRIED □ DIVORCED □ SINGLE or NEVER MARRIED
□ WIDOW □ LIVING WITH SIGNIFICANT OTHER

Ethnicity: □ Hispanic □ Asian □ Not Hispanic or Asian

Language: □ English □ Spanish □ Other _____

In case of an **emergency**, whom should we notify?

Contact Name: _____ Relationship: _____

Contact Number: _____
Who may we release **medical or appointment information** to?

Name: _____ Relationship: _____

Preferred Pharmacy: _____

Location: _____ Phone number (if available): _____

Preferred Lab: _____

Location: _____

Physician Name: _____ Specialty: _____

Location: _____ Phone number (if available): _____

How did you hear of us? (Please check all that apply):

□ Internet □ Magazine □ Newspaper
□ Billboard □ Mailer □ Staff Member
□ Friend or Client _____
□ Physician: _____
□ Other: _____

We are honored that you have chosen Allura Skin, Laser, and Wellness Center.
Please state the reasons for your visit:

_____

_____

Medical History

Weight: _____ **Height**: _____

Drug Allergies: □ NO □ YES List allergies: _____

Prescribed medications that you are currently taking and the dosage amount for each one:

_____ _____

_____ _____

_____ _____

_____ _____

Please list the **vitamins, supplements, and herbs** that you are taking:

_____ _____

_____ _____

Do you take Aspirin or other anti-inflammatory medications daily? □ Yes □ No
Are you currently taking Accutane? □ Yes □ No
Have you ever been tested for **HIV** □ Yes □ No
If yes, results were □ Negative □ Positive

Have you been diagnosed with **Hepatitis?** □ Yes □ No
If yes, please check which type:
□ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

Habits:
Do you smoke? □ Yes □ No
Age that you started smoking: _____
Number of cigarettes per day: _____
Do you drink alcohol? □ Yes □ No
On the average, how many drinks per week? _____
Do you use recreational drugs? □ Yes □ No

How often do you exercise? □ Daily □ 0-2 times per week □ 3-5 times per week

Skin Care History:
What types of **skin care products or product line(s)** are you currently using?

_____

_____

Are you sensitive to skin care products? □ NO □ YES
If yes, is sensitivity due to: □ Fragrances □ Irritation □ Rash □ Dryness

In your opinion, what **type of skin** do you have?
□ Dry □ Normal to Dry □ Normal □ Normal to Oily □ Oily Problem/blemished

How easy is it to tan your skin?
□ Always burn □ Burn at first, but can get a light tan □ Rarely burn, always tan
□ Never burn, easily tan □ Always tan

Have you been treated for **acne with** □ **oral medications,** □ **creams, or** □ **Accutane**?

Have you ever had any of the following **procedures** (please check all that apply)?
Please include approximate year:
□ Body Contouring (Thermage, VaserShape, or Other): _____
□ Botox/Dysport/Xeomin: _____
□ Chemical Peel_____
□ Facials: _____
□ Fillers: _____
□ Fractional Lasers (Fraxel or CO2 or Sublative or Other):_____
□ Hair Removal (Electrolysis, Wax or Dermablading): _____
□ IPL (intense pulse light) or FotoFacial: _____
□ Laser Hair Removal: _____
□ Microderms: _____
□ Permanent Make-Up: _____
□ Skin Tightening of Face or Eyes (Thermage or Other): _____
□ Teeth Whitening: _____
□ Vein Treatment: _____

Have you had any **adverse reactions** to any of the treatments listed above? □ NO □ YES
If yes, please explain the reactions:

_____

_____

Please mark all that apply:

□ Active acne
□ Anemia
□ Asthma
□ Bladder Infections
□ Blood clots
□ Celiac Disease
□ Colon CA
□ Crohn's Disease
□ Diabetes
□ Emphysema/COPD
□ Fibrocystic breasts
□ Goiter
□ Hashimoto's
□ High Cholesterol
□ Hypertension
□ Irritable Bowel Syndrome
□ Lactose Intolerance
□ Lupus Arthritis
□ Murmur
□ Rheumatoid Arthritis
□ Scleroderma
□ Stroke
□ Thyroid Nodule
□ Ulcers
□ Age Spots//Brown spots
□ Anxiety
□ Atypical Moles
□ Bleeding Disorders
□ Blood Transfusions
□ Chronic pain
□ Colon Polyps
□ Degenerative Disc Disease
□ Eating Disorder
□ Facial hair growth
□ Fibromyalgia
□ Hair Loss
□ Headaches/Migraines
□ History of skin cancer
□ Hypothyroid
□ Keloid scarring
□ Leg Veins
□ Metabolic Syndrome
□ Osteopenia/osteoporosis
□ Rosacea
□ Sleep Apnea
□ Sun-damaged skin
□ TIA
□ Allergies
□ Arthritis
□ Augmentation of Breasts
□ Blood Cancers
□ Breast Reduction
□ Cold sores
□ Cosmetic surgery
□ Depression
□ Eczema/psoriasis
□ Facial Veins
□ Gluten Intolerance
□ Hair Thinning
□ Heart Attack
□ Hyperthyroid/Graves'
□ Irregular heart rate
□ Kidney Stones
□ Lung Cancer
□ Multiple Sclerosis
□ Reflux
□ Scars
□ Stretch Marks
□ Thyroid Cancer
□ Varicose veins
□ Other illnesses not listed above: _____

Surgeries:
List all **major surgeries**:

_____

_____

Please list **outpatient procedures, surgeries and hospitalizations** (including year and reason):

_____

_____

Have you had any major accidents: □ Yes □ No

Family Medical History:

□ Alcohol or Drug Abuse
□ Celiac Disease
□ Dementia
□ Heart Disease/MI
□ Hypertension
□ Osteoporosis/Osteopenia
□ Psychiatric Disorders
□ Skin Cancers
□ Thyroid Cancer
□ Bladder Cancer
□ Cervical Cancer
□ Depression
□ Hereditary Blood Disorders
□ Lung Cancer
□ Ovarian Cancer
□ Prostate Cancer
□ Stroke
□ Thyroid Disease
□ Breast Cancer
□ Colon Cancer
□ Diabetes
□ High Cholesterol
□ Lupus
□ Parkinson's Disorders
□ Rheumatoid Arthritis
□ Suicide
□ Uterine Cancer

Other illnesses or disease not listed:

_____

Authorizations:
I consent to the taking of photographs for the purpose of documentation and future comparison.
Initial _____

I authorize the release of information to/from my primary care physician or specialist if deemed necessary for the treatment.
Initial _____

I understand that **my insurance company will not cover any of the procedures performed**.
Initial _____

Payments for all procedures or services are to be paid at the conclusion of each visit.
Initial _____

I understand that procedure packages are non-transferable.
Initial _____

I authorize that the above information is up to date and correct to the best of my knowledge.
Initial _____

Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Please complete the remaining pages for your
Bio-Identical Hormone Replacement Therapy Consultation and Insertion

Health Maintenance:			**Normal:**	
Mammogram in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Bone density in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Medical/Gyn exam in previous 24 months:	□ YES	□ NO	□ YES	□ NO
Pap Smear in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Pelvic Ultrasound in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Performs Regular Self Breast Exams:	□ YES	□ NO	□ YES	□ NO

OB/GYN History:
Number of pregnancies _____
Number of live birth: _____
Number of miscarriages: _____
Sexual orientation: □ Heterosexual □ Homosexual □ Bisexual

Check all that apply:

□ Regular Periods	□ Irregular Periods	□ Abnormal Pap
□ Abnormal Uterine Shape	□ Breast Cancer	□ C-Section(s)
□ Cone Biopsy of cervix	□ Colposcopy	□ Cryogen Treatment
□ Fibroids	□ Genital Herpes	□ H/O Pelvic Infections
□ Hysterectomy	□ Infertility	□ Laser Treatment for cervix
□ Menopause	□ Ovarian Cancer	□ STD(s)
□ Uterine Ablation	□ Uterine Cancer	□ PCOS (polycystic ovarian syndrome)

What type of contraception are you currently using (check all that apply)?

□ NONE □ Condoms □ Depo Provera □ Diaphram
□ Foam □ Hysterectomy □ IUD □ Natural Family Planning
□ Norplant □ Oral Contraception □ Plan B □ Tubal Ligation
□ Vasectomy □ Withdrawal

8SYMPTOM CHECKLIST

Please circle the symptoms you are experiencing and the frequency or severity of the symptoms:

Estrogen Related Symptoms:

Night Sweats: □ <3 times/week □ 1-3 times per night □ >3 times/night
Sleeping problems: □ Never □ 1-3 awakenings/week □ Sleep disturbance every night
Hot flashes/warm flushing: □ Never □ 1-3 flashes/night □ Frequently-Daily/Nightly
Pain with intercourse: □ Never □ Once in a while □ More often □ Always
Vaginal dryness: □ Never □ Once in a while □ Worsening □ Always
Urine leakage: □ Never □ When I cough, sneeze, or exercise □ Daily

Testosterone Related Symptoms:

Sexual Desire/Libido: □ Not a problem □ Less Desire □ No Desire
Difficulty Concentrating: □ Not a problem □ Worsening
Memory Loss: □ Not a problem □ Worsening or more forgetful
Foggy Thinking: □ Not a problem □ Worsening
Muscle Pain □ Never □ Occasionally □ More Often □ Daily
Joint Pain □ Never □ Occasionally □ More Often □ Daily

Estrogen and Testosterone Related Symptoms:

Mood Swings: □ No □ Before my Periods □ Getting worse & not sure why
Migraines/Headaches: □ Never □ 1-2 times/month □ More frequent/getting worse □ Daily
Depression: □ No □ Sad more than usual □ Affecting my job/relationships
Anxiety: □ No □ Worsening □ Affecting my job/relationships

Please initial then sign below:

I authorize that the above information is up to date and correct to the best of my knowledge.
Initial _____

Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Thank you for completing the Health History Form!