



Female Patient Questionnaire & History

Name: _____ Goes By: _____ Todays Date: _____

Date of Birth: _____ Age: _____ Occupation: _____ Place of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? **YES / NO**

Marital Status (check one): () Married () Divorced () Widow () Living with Partner () Single

Gender: _____ Race: _____ Ethnicity: _____ Preferred Language: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Gynecologist Name: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____

Member ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Company: _____

Member ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____



Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes please explain: _____

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:

() Pap Smear Date: _____

() Mammogram Date: _____

() Bone Density Date: _____

() Pelvic ultrasound Date: _____

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:

() 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: _____



Review of Symptoms (Mark only those which you have)

General:

- Fever/Chills
- Fatigue
- Night Sweats
- Weight Change
- Headaches
- Dizziness
- Loss of consciousness
- Head Injury

Nose:

- Altered sense of smell
- Nose Bleeds
- Postnasal Drip
- Sinus pain/pressure

Endocrine:

- Thyroid enlargement
- Hot/Cold intolerance
- Increased urination
- Increased thirst
- Increased appetite
- Changes in facial/body hair

Heart and Circulation:

- Chest pain
- Palpitations
- Exercise intolerance
- Leg swelling
- History of heart attack
- High blood pressure

Gastrointestinal:

- Loss of appetite
- Painful swallowing
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea

Skin, Hair, and Nails:

- Rash
- Skin Change

- Nail changes
- Excessive sweating

Eyes:

- Blurred vision
- Double vision
- Eye pain
- Change in vision
- Glaucoma

Women's Health:

- Age at first period
- Painful cycles
- Irregular cycles
- Vaginal Dryness
- Bleeding between cycles
- Vaginal irritation/itching
- Change in libido
- Number of pregnancies
- No. of miscarriages/abortions
- History of C-Sections
- Premature deliveries
- Use of birth control

Neurologic:

- Weakness
- Abnormal sensation
- Abnormal coordination
- Memory Loss

Lymph Nodes:

- Enlargement/tenderness

Musculoskeletal:

- Joint pain/stiffness
- Restricted motion
- Swelling
- Bone Deformity

Ears:

- Hearing loss
- Ear pain
- Drainage
- Ringing in ears

Throat and Mouth:

- Hoarseness
- Sore throat
- Toothache
- Tongue swelling
- Ulcers
- Taste Disturbance

Respiratory:

- Pain with breathing
- Wheezing
- Cough
- Sputum
- Coughing up blood

Hematologic/Blood:

- Anemia
- Bruise easily
- History of transfusion
- Blood cell disorders

Genitourinary:

- Painful urination
- Increased frequency of urination
- Nighttime urination
- Incontinence

Psychiatric:

- Depression
- Mood changes
- Difficulty concentrating
- Suicidal thoughts
- Sleep disturbance
- Anxiety



Do You Still Have Your Uterus _____ Do You Still Have Your Ovaries _____ Age of Ovary Removal _____
 Contraception/Birth Control Used _____ No. of Pregnancies _____ Living Children _____
 Premature Births _____ Abortions/Miscarriages _____

Menopausal Symptoms You Are Experiencing: _____

List Parents and Siblings, their ages, if they have any health issues, and if they passed away, the cause of death. Also List family members that have passed away from cancer and what type of cancer they had:

List Medications That Your Close Family Members Have Taken for the Same Symptoms and Received Results:

Health Problems: _____

Social:

- () 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.

Habits:

- () I smoke cigarettes or cigars _____ per day.
- () I drink alcoholic beverages _____ per week.
- () I drink more than 10 alcoholic beverages per week.
- () I use caffeine _____ times a day.
- () I use drugs _____ times a day. Type(s) of drug(s) _____.

Patient/Guardian Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____

Menopause and Hormone Specialty Center, LLC
7591 Fern Avenue, Suite 1501
Shreveport, LA 71105
(318) 524-8032 Office
(318) 524-8033 Fax

Consent for Hormone Replacement Therapy

Date: _____

I, _____ give Tammi Herkey, WHNP-C and Menopauses specialist permission to prescribe me any hormone regiment that will make me feel better, relieve my symptoms and improve my quality of life. I have no history of breast cancer and no history of heart disease.

I, _____ have a history of heart disease but my cardiologist gives me permission to take hormone replacement therapy. Provide a not from cardiologist stating it is okay to take hormone replacement therapy.

I, _____ have had breast cancer but my oncologist allows me to take vaginal estrogen therapy only and testosterone and progesterone in any form. Provide a note from oncologist stating it is okay for her to take for her to take hormones testosterone and/or progesterone and only vaginal estrogen therapy.

I, _____ will not hold Tammi Herkey WHNP-C and Menopause Specialist liable if after taking HRT (Hormone Replacement Therapy) should I develop breast cancer or heart disease. It is my choice to take the medications and in no way I was forced to HRT.

Patient Print Name

Patient Sign Name

Provider Print Name

Provider Sign Name

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Consent for Treatment without Direct Supervision by a Physician

This consent serves as notice that care given at the Menopause and Hormone Specialty Center, LLC is not done so under the "direct supervision" of a physician, and there is no physician located on site responsible for the evaluation and management decisions made.

While the Menopause and Hormone Specialty Center, LLC is responsible for your test results, you are to be advised that these results, including blood tests, mammograms, and any other diagnostic tests performed during the course of your treatment will not be routinely reviewed by, nor the validity of the results verified by, the collaborative physician.

Signing this consent gives Tammi Herkey, MS, APRN, WHNP-C, CMC the right to treat your hormone specific needs under the scope of her practice and specialized training, without direct supervision by a physician, and releases the collaborative physician of liability for any treatment outcome or test result provided without specific request for interpretation and collaboration.

Date

Patient Name

Patient Signature

Provider Name

Provider Signature

Witness Name

Witness Signature

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7591 Fern Avenue, Suite 1501
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318-524-8032 Phone
318-524-8033 Fax
menopausehormones@gmail.com

Potential Risk of Testosterone Therapy

Date: _____

There is no research on women and testosterone therapy except for the WHI (Women's Health Initiative) Study. In that study the average age of the women were 65 and had never been on HRT (Hormone Replacement Therapy) before. Most of the women in the study were also overweight. The study showed an increase in breast cancer among women who took both estrogen and testosterone therapy. Over the age of 60 women are at an increased risk of breast cancer even if they do not take HRT.

The findings in men showed if they are over the age of 65 they had an increased risk of a heart attack within 90 days of starting testosterone therapy. Men under the age of 65 showed no increased risk of heart attack unless they had a history of heart disease.

Testosterone has been shown to increase bad cholesterol (LDL) and lower good cholesterol (HDL). It can also elevate your Hgb and Hct. Women placed on testosterone therapy will be closely monitored. Baseline labs will be drawn prior to treatment and follow up labs at least once a year.

If you still desire to receive testosterone therapy understanding these risk factors, please sign the consent below. By signing this consent, you are taking full responsibility of any potential risks that may occur with you taking testosterone therapy.

Patient Name Printed

Patient Name Signed

Provider Name Printed

Provider Name Signed

Witness Name Printed

Witness Name Signed

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Potential Risk When Taking Thyroid Medications for Hypothyroidism

Date: _____

When taking thyroid medications it is very important that you are monitored closely. Having serum levels checked every 3-6 months.

When taking thyroid medications for hypothyroidism you can be at risk of hyperthyroid if your serum levels are too high.

If this occurs you are at risk of:

Heart Problems – rapid heart rate, atrial fibrillation, and congestive heart failure

Brittle Bones – osteopenia or osteoporosis

Eye Problems – red or swollen eyes, sensitivity to light, visual changes

*Thyrotoxic Crisis – sudden intensification of your symptoms, leading to fever, rapid pulse, and even delirium. **If this occurs, seek immediate medical attention.***

By signing this consent you are taking full responsibility of any potential risks that may occur with you taking medications for your hypothyroidism.

Patient Name Printed

Patient Name Signed

Provider Name Printed

Provider Name Signed

Witness Name Printed

Witness Name Signed

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Appointment Cancellation and Rescheduling

This notice is to inform you that if you do not give us 24 hour notice of your appointment needing to be rescheduled there will be a \$25.00 fee for not cancelling your appointment 24 hours in advance. Signing this form makes you accountable for your appointments and enables me to bill you for the \$25.00 fee.

When you no show or cancel the day of your appointment it prevents us from seeing another patient in your slot that has been waiting to see me. Please note, I am having to do this because of an increase of patients no showing or cancelling their appointment the day it is scheduled for.

Thanks for your co-operation in this matter.

Sincerely,

Tammi K. Herkey, Owner

Date

Print Name

Sign Name

*This includes all appointments including injections.

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CONSENT FOR TREATMENT

I consent to services, treatment, and diagnostic procedures; including, but not limited to medications, lab tests, and other studies which may be ordered by my physician at Menopause & Hormone Specialty Center, LLC. I have the right to ask questions and receive information about any services that I may receive.

Signature: _____ **Date:** _____

Patient Name: _____

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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information I understand that this information can and will be used to:

- Obtain payment at the time of your visit.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name Printed

Patient Signature

Date

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Fax Number: (318)-524-8033

E-mail Guidelines:

The staff of Menopause and Hormone Specialty Center, LLC welcomes your contact. We also value your privacy and time and therefore offer the following information to help you decide on the best method for reaching us. We hope that these guidelines are helpful to you as you decide how best to reach our staff. We take your time and confidentiality very seriously and therefore consider it imperative that you understand the limitations of our use of e-mail technology.

- When we respond to your e-mail, we will respond to the address from which it is sent. If you do not wish others who may have access to the e-mail account you are using to also have access to our response, please consider another means of communication.

On-line Medical Advice:

Unfortunately, e-mail is not an appropriate medium for medical advisement, so if there is ever an issue of not understanding, please e-mail us back and ask us to clarify, or try another means of communication or call our office and schedule an appointment for Medical Advice.

How quickly can you expect a reply?

While we try to check our e-mail regularly, you have no way of knowing if one of us is unavailable due to illness, vacation, or other reasons, or if there are problems with the network itself. This means that your message may not be received immediately.

Contact:

If time is of particular concern for you, you should consider calling our office at (318)-524-8032.

E-mail Address: _____

I understand that e-mailing information to and from Menopause and Hormone Specialty Center, LLC may not be the most secure way of communicating; However, I give Menopause and Hormone Specialty Center, LLC permission to e-mail me regarding appointment scheduling, lab results, prescription refills, or anything else regarding my care at the office.

Patient Name: _____ Patient Signature: _____

Witness Signature: _____ Date: _____

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**PATIENT REQUEST FOR PROTECTED HEALTH
INFORMATION AND DISCLOSURE**

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip code: _____

Date of Birth: _____ Social Security Number: _____

Please consider this request for me to exercise my rights under federal and state law to request confidential communication of my protected health information.

Please explain below whom, specifically, you want to grant the use of your protected health information:

Name of Person(s):

Relationship:

I understand that the physician (or provider) to whom I am making this request will make responsible efforts to accommodate this request. I understand that the physician (or provider) is not required to honor this request when information about me is needed for emergency treatment or in various instances when the information is permitted, by law, to be released. I further understand that the physician (or provider) may terminate this restriction and I will be informed of the termination. I may also choose to terminate this restriction and may do so orally or in writing.

Signature: _____

Date: _____

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We do not accept any Medical Insurance

I am so sorry to have to inform you that I do not accept any form of insurance. This has come about due to the fact that insurance companies keep decreasing the amount they are reimbursing providers and the cost of running a medical office keeps rising. Not to mention on October 1, 2015 ICD 10 codes was implemented making it harder to get payment from insurance companies.

You are still able to come see us even though we will not be accepting any insurance. The main difference is you will have to pay up front for your office visit. We will provide you a statement you can turn into your insurance company and have them reimburse you for the office visit. Sorry, to say again, they will not reimburse you for the office visit because I do not have a contract with any insurance company.

Times are tough all around, that I know, but with the changes in the medical industry, more and more medical providers will no longer be accepting insurance because they can no longer run their business based on the amount insurance companies are paying to providers for services rendered. Or they will be joining big groups to cut down on over head

Listed below are the prices for services.

New Patient Visit	\$130.00
Follow Up Visit	\$85.00
Pellet Insertion	\$350.00
O-Shot	\$1200.00

Thank you for your time and understanding,

Tammi Herkey

Date: _____

Print Patient Name

Print Witness Name

Patient Signature

Witness Signature

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Notice of Privacy Practices
Effective: November 1, 2007

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions, please contact our office at the address and/or phone number at the beginning of this notice.

Who Will Follow This Notice?

The offices of Menopause and Hormone Specialty Center, LLC provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed:

- * Any healthcare professional that treats you at any of our practices.
- * All employed associates, staff, or volunteers of our organization.
- * Any business associates or partners of Menopause and Hormone Specialty Center, LLC with whom we share health information.

Our Pledge to You

We understand that medical information about you is personal. We are committed to protecting medical and billing information about you. We create a designated record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to:

- * Keep medical and billing information about you private.
- * Give you the notice of our legal duties and privacy practices with respect to your protected health information.
- * Follow the terms of the notice currently in effect.

Changes in This Notice

We may change our policies and privacy practices at any time. Changes will apply to your protected health information obtained after the change occurs. When we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and/or exam rooms.

You can receive a copy of current notices at any time. This effective date is listed below the title. You will be offered a copy of the current notice on the first service delivery from November 1, 2007. You will also be asked to acknowledge, in writing, your receipt of this notice.

How We May Use & Disclose Your Protected Health Information

We may use and disclose medical and billing information about your **treatment** (such as sending medical information about you to a specialist as part of a referral); to **obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and to **support our healthcare operations** (such as comparing patient data to improve treatment methods).

Subject to certain requirements, we may give out protected health information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections,

research studies, funeral arrangements, organ donations, worker's compensation purposes, and during emergencies. We may also disclose protected health information when **required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We may contact you for **appointment reminders**, or to tell you about or recommended **possible treatment options, alternatives, health-benefits, or services that may be of interest to you**.

We may disclose medical information about you to a **friend or family member who is involved in your medical care** or to disaster relief authorities so that your family can be notified of your location and condition.

Other Uses of Medical Information

In any other situation not covered by this notice, we will ask for written authorization before using or disclosing your protected health information. If you choose to authorize our use or disclosure of your protected health information, you can later revoke that authorization by notifying us, in writing, of your decision.

Your Rights Regarding Medical Information About You

In most cases, **you have the right to look at or get a copy of medical information** that we use to make decisions about your care, when you submit a written request. If you request copies, we will charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to obtain a copy, you may submit a written request for review of that decision.

If you believe that information in your record is incorrect or missing, **you have the right to request that we correct the records**. Your request must be submitted in writing. A request for amendment must provide your reason for the amendment. We could deny your request to amend a record of the information if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, healthcare operations, or where you specifically authorize a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period starting after November 1, 2007. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us, in writing, of the specific way or location for us to communicate with you.

You may request in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your case except when specifically authorized by you, when required by law, or in an emergency. We will consider your request, **but are not legally required to accept it**. We will inform you of our decision on your request.

All written requests or appeals should be submitted to our office staff or your physician.