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: _____

Patient Name: _____ Date of Birth: _____

MEDICATION LIST

Date Started	Medication (name, strength, frequency)	Date Ended

Financial Policy:

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 Passed Away, 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 _____.

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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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.

If you are currently on Synthroid, Cytomel, or Armour Thyroid prescribed by me and desire to continue to do so, please sign the consent below. 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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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, bit if the organization does agree, then it is abound 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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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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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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We do not accept any Medical Insurance

I am so sorry 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 keep rising. Not to mention 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 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. They may not reimburse you for the office visit because I do not have any contracts with insurance companies.

Listed below are the prices for services.

New Patient Visit	**$130**
Follow up Visits	**$85**
Pellet Insertion	**$350**

Thank you for your time and understanding,

Tammi Herkey

Date:_____

_____ _____

Print Name **Patient Signature**

_____ _____

Print Witness Name **Witness Signature**

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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