PSL Concierge Medicine
Bio-Identical Hormones

Female Patient Questionnaire & History

Name: ____ Today's Date: ________

(Last) (First) (Middle)

Date of Birth: __________ Age: ____ Weight: _____ Occupation: ________________

Home Address: ____

City: ____ State: _______ Zip: ___________

E-Mail Address: ____________________ May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: __________________ Relationship ________________

Home Phone: _________________________ Cell Phone: _______ Work: ___________

Primary Care Physician's Name: ___________________________ Phone: ___________

Address: ____

Address City State Zip

Gynecologist's Name: ___________________________________ Phone: ___________

Address: ____

Address City State Zip

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

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment.

Spouse's Name: __________________________________ Relationship: _____________

Home Phone: _________________________ Cell Phone: _______ Work: ___________

( ) I am sexually active.

( ) I want to be sexually active.

( ) I have completed my family.

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

( ) I smoke cigarettes or cigars _____ per day.

( ) I drink alcoholic beverages ________ per week.

( ) I use caffeine _____________ a day.

Past Medical History

Any known drug allergies: ______________________________

Medications Currently Taking: ______________________________

Pharmacy Name and Phone: ______________________________

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 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.

Medical Illnesses:

( ) Polycystic Ovary pressure.

( ) 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: ______________

Birth Control Method:

( ) Menopause.

( ) Hysterectomy.

( ) Tubal ligation.

( ) Birth Control Pills

( ) Vasectomy.

( ) Other: ______________________________

BHRT Checklist For Women

Name: ____ Date: ______________

E-Mail: ____

Symptom (Please check mark)	Never	Mild	Moderate	Severe
	____	____	____	____
Depressive mood	____	____	____	____
Memory Loss	____	____	____	____
Mental confusion	____	____	____	____
Decreased sex drive / libido	____	____	____	____
Sleep problems	____	____	____	____
Mood changes / Irritability	____	____	____	____
Tension	____	____	____	____
Migraine / severe headaches	____	____	____	____
Difficult to climax sexually	_____	____	____	____
Bloading	____	____	____	____
Weight gain	____	____	____	____
Breast tenderness.	____	____	____	____
Vaginal dryness	____	____	____	____
Hot flashes	____	____	____	____
Night sweats	____	____	____	____
Dry and wrinkled skin	____	____	____	____
Hair falling out	____	____	____	____
Cold all the time	____	____	____	____
Swelling all over the body	____	____	____	____
Joint pain	____	____	____	____

Family History

	NO	YES
Heart Disease	___	___
Diabetes	___	___
Osteoporosis	___	___
Alzheimer's Disease	___	___
Breast Cancer	___	___

Past Medical History

Please list any medical problems. Include any hospitalizations and accidents with dates.

Personal Data

Medications. Please list ALL prescription medications. Include ALL over the counter medications, supplements, and vitamins.

Past Surgical History

Date   Surgery

Primary Care Physician

Name	Phone / Fax Number	
Address	City, State	Zip
Pharmacy Name	Phone / Fax number	

Present Symptoms

Please briefly describe your symptoms

Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC)

Family History

What do you feel is the most important factor to your present symptoms?

Please list ALL illness (heart diseases, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. It a member is deceased, please list age of death and cause, if known.

Relationship	**Age**	**Medical Problem(s) / Cause of Death**
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? [ ] Yes. [ ] No

If yes, how many drinks and what type of alcohol (beer, wine, spirits, etc.) do you have in an average week?

____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc? [ ] Yes. [ ] No

If yes, what substance(s) and how often”

____

Gynecological History

Date of last PAP smear? _____________ Physician who performed? ___________

Physician’s Phone Number ____________________

Date of last mammogram? ______________ Facility where performed __________

Facility Phone Number _________________

Have you ever had an abnormal PAP smear? If yes, what was the YES. NO

abnormality and what follow up did you have _____________________

Have you ever had an abnormal mammogram? If yes, what was the

Abnormality and what follow up did you have _____________________

Have you ever had a breast biopsy?

Have you have had a cervical biopsy?

Have you noticed breast skin or nipple changes?

Have you noticed any lumps in your breasts?

Are you using a birth control method? If yes, what kind?

____

Are you still having menstrual periods? If yes, when was the first day of Your last period? ____

Please describe any problems you have with your periods:

____

Periods are (were) [ ] regular [ ] irregular [ ] painful [ ] campy [ ] heavy [ ] light [ ] other

Age periods began:_____ # days of bleeding ________ cycle length (days) ____

If you are no longer having periods, at what age did your periods stop? _____

If your periods stopped less than one year ago, how many months ago was your last period? __________

Did your periods stop because you had a hysterectomy? [ ] Yes [ ] No

- If yes, what was the reason for the surgery?__________________________
- Were the ovaries removed at the same time? Yes [ ] No [ ] Not sure [ ]

Do you have a history of the following cancers:

[ ] Vulva	[ ] Ovary	[ ] Other _______________________
[ ] Uterus	[ ] Fallopian tube	_______________________
[ ] Vagina.	[ ] Breast	
[ ] Cervix	[ ] Colon	

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, give a approximate Periods of treatment

Hormone   DosE. Reason   Start Date   Stop Date

Estrogens

Check which of these symptoms are troublesome and have persisted over time

Estrogen Deficiency	Estrogen Excess / Progressive Deficiency	
[ ] Hot Flashes	[ ] Mood Swings (PMS)	[ ] Uterine Fibroids
[ ] Night Sweats	[ ] Cystic Ovaries	[ ] Weight Gain - Hip Area
[ ] Vaginal Dryness	[ ] Tender Breasts	[ ] Bleeding Changes
[ ] Foggy Thinking Triglycerides	[ ] Heavy Menses	[ ] Elevated
[ ] Memory Lapses	[ ] Water Retention	[ ] Breast Cancer
[ ] Urinary Incontinence	[ ] Sugar Craving	[ ] Low Libido
[ ] Tearful	[ ] Nervousness	
[ ] Depressed	[ ] Irritable	
[ ] Sleep Disturbances	[ ] Anxious	
[ ] Heart Palpitations / Arrhythmia	[ ] Fibrocystic Breast	
[ ] Bone Loss	[ ] Headaches	
[ ] Headaches	[ ] Cold Body Temperature	

Androgens

[ ] Increased Facial Hair	[ ] Low Libido	[ ]HeartPalpitations / Arrhythmia
[ ] Increased Body Hair	[ ] Vaginal Dryness	[ ] Headaches
[ ] Acne	[ ] Fatigue	[ ] Fibromyalgia
[ ] Oily Skin	[ ] Aches/Pains	[ ] Irritable
[ ] Nervous	[ ] Mempry Lapses	[ ] Thinning Skin
[ ] Irritable	[ ] Foggy Thinking	[ ] Bone Loss
[ ] Anxious	[ ] Urinary Incontinence	
[ ] Breast Cancer	[ ] Depressed	
[ ] Ovarian Cysts	[ ] Anxious	
[ ] Elevated Triglycerides	[ ] Sleep Disturbances	
[ ] Sleep Disturbances	[ ] Apathy / Decreased Passion for Life	
[ ] Prostrate Problems	[ ] Decreased Muscle Mass	

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess **Cortisol Deficiency**

[ ] Sleep Disturbances	[ ] HeartPalpitation/Arrhythmia	[ ] Exhaustion / Fatigue
[ ] Bone Loss	[ ] Headaches	[ ] Sugar Craving
[ ] Fatigue	[ ] Stress	[ ] Allergies
[ ] Weight Gain - Waist	[ ] Nervousness	[ ] Chemical Sensitivity
[ ] Loss of Muscle Mass	[ ] Sugar Cravings	[ ] Stress
[ ] Thinning Skin	[ ] Low Libido	[ ] Apathy / Decreased Passion for LIfe
[ ] Elevated Tryglycerides	[ ] Hair Loss	
[ ] Breast Cancer	[ ] Increased Facial Hair	[ ] Irritable
[ ] Irritable	[ ] Increased Body Hair	[ ] Arthritis
[ ] Anxious	[ ] Acne	[ ] Heart Palpitations
[ ] Memory Lapses		[ ] Aches / Pains
		[ ] Cold Body Temperature

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency	
[ ] Heat intolerance	[ ] Cold Intolerance	[ ] Aches / Pains
[ ] Irritable	[ ] Constipation	[ ] Hair Loss
[ ] Heart Palpitations/Arrhythmia	[ ] Fatigued / Weakness	[ ] Muscle Weakness
	[ ] Unexplained Weight Gain	[ ] Muscle Cramps
[ ] Weight Loss	[ ] Inability to Lose Weight	
[ ] Tremors/Shakiness	[ ] Stress	
[ ] Diarrhea	[ ] Cold Body Temperature	
[ ] Nervousness / Anxious Panic Attacks.	[ ] Coarse Dry Skin	
[ ] Insomnia	[ ] Lack of Motivation	
[ ] Difficulty Conceiving / Infertility	[ ] Voice has become hoarse	

System Review - Check the appropriate box for each question.

Constitutional / ID / Oncology **Yes No Not Sure**

Have you ever had unexplained weight loss?
Do you have fever or chills?
Do you have night sweats?
Do you notice swollen lymph nodes?
Have ever been diagnosed with cancer?
Have you ever been tested for HIV?
Have you had a Sexually Transmit Disease?
Do you have a persistent cough?
Do you have recurrent sinus infections?

Do you have excessive daytime sleepiness?

Do you snore?

Have you ever been diagnosed with asthma or emphysema?

System Review - Check the appropriate box for each question.

Cardiovascular	Yes	No	Not Sure
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Vascular disease or artery blockages/aneurysms?			
Have you ever been diagnosed with any heard condition?			
Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			

Do you have muscle weakness?

Have you ever had a seizure?

Have you ever fainted?

Have you experienced double vision or blind spots?

Have you ever been diagnosed with a stroke?

Urologic / Renal

Do you have burning when you urinate?

Do you have urgency when you urinate?

Do you urinate more frequently than others?

Do you leak urine when laughing or coughing?

Have you ever had any kidney problems?

Provider's Notes:

Patient SOAP Notes Form

Patient Name | Date

Reason for visit | Type of visit

[ ] Initial [ ] Follow-up [ ] Final

Tests Ordered or Received

CBC

Skin Tests

PFT

Radiology

Request Medical Records [ ] Yes

Review of Records

Subjective Data (Symptoms / Content)

Objective Data (Observation. Labs)

Assessment / Diagnosis or Impression **Code**

Plan / Medications

Follow-Up. [ ] Days [ ] Weeks. [ ] Months. [ ] PRN

Signature Time In Time
Out

AM PM [ ] AM. [ ] PM [ ]

Disclosure / Liability Waiver

PSL Concierge Medicine - Bo-Identical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may

occur that are beyond the control of our physicians or staff. Whithin the medical commnity, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormone's does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from PSL Concierge Medicine, LLC. Its staff, or treating providers for injury to you on account of involvement in the Bio-Identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

____ ________________

Signature of Patient Date

____ ________________

Print Name Date

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement of acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, mammogram, prostate examination, and PSA testing. Your signature below indicates that you will comply why obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

____ ________________

Signature of Patient Date

____ ________________

Print Name Date