Optimal Hormone Health & Wellness

9001 Forest Crossing Drive, Ste D-2
The Woodlands, Texas 77381
(281) 465-9209
(281) 651-4875-fax

Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Ht: _____' _____" Wt: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Social Security #_____

Home Phone: _____ Cell Phone: _____ Work: _____

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

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

( ) I give OHHW permission to contact the following individuals to discuss any portion of my treatment plan (please include spouse or significant other)

Name: _____ Relationship: _____ Phone (home): _____

Phone (cell): _____

Name: _____ Relationship: _____ Phone (home): _____

Phone (cell): _____

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 a week.
( ) I use caffeine _____ a day.

How did you hear about us?_____

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Medical History

Any known drug allergies: _____

Medications Currently Taking (including vitamins and nutritional supplements):

Name of Medication/Supp.	Dose	Frequency	Reason taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin/Herbal Supplements: _____

Surgeries, list all and date: _____

Have you ever had any issues with anesthesia? ( ) Y ( ) N If yes please explain: _____

Are you or could you be pregnant? ( ) Y ( ) N Last menstrual period (estimate year if unknown) _____

Other Pertinent Information: _____

Preventative Medical Care:

( ) Medical/GYN Exam Date:_____
( ) Mammogram Date:_____
( ) Bone Density Date:_____
( ) Pelvic Ultrasound Date:_____
( ) Colonoscopy 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:_____

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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				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Fatigue				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

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Office Policies and Procedures for Patients

(Please initial in the spaces provided and sign the bottom)

Office Hours:
_____ Office hours for Optimal Hormone Health & Wellness (OHHW) are as follows: Monday – Thursday: 9:00 a.m. – 5:00 p.m. (closed noon - 1:30) and Friday: 9:00 a.m. – 1:00 p.m. If you need an appointment or prescription refill, please call during regular business hours.

Appointments:
_____To ensure timely service and medical care, we encourage you to schedule your appointment in advance. If you must cancel your appointment, please give our office 24-hour advanced notice. This gives us an opportunity to reallocate time for another patient. If you are unable to provide a 24-hour notice of cancellation, **you will be charged $50**, to be paid at your next appointment.

Late Arrivals:
_____It is our goal to provide quality time and care to each patient. While we understand there may be some things out of your control, we encourage you to be **ON TIME** for appointments. Late arrivals may interfere with another patient's care. We will do our best to accommodate you if you are running late but depending on scheduling, it may be necessary to reschedule.

No Show:
_____A "no show" is someone who misses an appointment without calling or fails to give 24-hours notice. Three (3) "no shows" within one calendar year may result in loss of service. You will also be billed **a "no show" fee in the amount of $50**, to be paid at the time of your next visit.

Prescription Refills and Pharmacy Information:
_____Please do not wait until the last minute for refill requests. Please plan ahead and allow 2 full business days to complete refill requests. Refill requests must be done during normal business hours. We do not have access to your patient record after hours, therefore, no medications will be refilled after hours or on weekends. If your prescription is lost, expired, or must be replaced, a replacement must be picked up at the office. There will be a **$25 fee for replaced prescriptions.** Please review your medications prior to appointments and request refills at the time of visit, if needed. Every patient will be given enough medication to last until the next recommended office visit and/or lab draw.

Insurance Disclaimer:
_____OHHW is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, office visits, or pellets). We will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. The form and the receipt are your responsibility. WE WILL NOT, communicate in any way with insurance companies regarding your benefits.

HIPAA Information and Consent Form:
_____I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM, a copy of which has been provided to me by OHHW, and any subsequent changes in office policy. I understand that this consent shall remain in force from this date forward.

Medical Records:
_____To ensure your privacy, copies of medical records must be requested in writing per HIPPA guidelines and a medical release form must be completed in advance. Medical records can be faxed or mailed to other clinicians but cannot be emailed due to confidentiality concerns. The law allows medical offices 30 days to complete requests for records. It is our goal to respond to your request in a timely manner. **There is a $25 fee to copy medical records for patients. The request for records to be sent to another clinician is free.**

Forms and Letters:
_____OHHW will assist in the completion of certain forms and letters as follows: 1) Letters of Necessity, 2) Prior Authorizations for prescriptions only, and 3) Employment Physical forms. Please allow 7-10 days for completion of requested forms/letters. There will be a $**25 charge for the completion of short forms** and letters and a **$45 charge for more extensive forms/letters.**

Right to terminate:
_____OHHW reserves the right to terminate services due to failure to comply with policies and procedures. OHHW reserves the right to terminate services due to inappropriate and/or threatening behaviors and/or comments made to clinicians and/or staff.

OHHW Pricing:
_____I have reviewed and understand OHHW's price policy and further understand that **payment is due upon receipt of services rendered**. I understand that I may request a copy of OHHW's price list at any time and it will gladly be provided to me.

Printed name:_____Signature:_____Date:_____

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Testosterone and/or Estradiol Pellet Insertion Consent Form

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal glands prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are made from soy and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)
Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; hair thinning and hair loss (rare) water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia

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 there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and 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. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____ _____

Patient Signature **Today's Date**

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Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. You may replace it with a bandage to catch any anesthetic that may ooze out. The inner layer consists of steri-strips. The steri-strips should not be removed before 4 days.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for 3 days. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next 4 days. This includes running, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days. Don't worry…..this is normal.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 25-50 mg. orally every 6 hours. Caution, this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any continued bleeding (not oozing) or pus coming out of the insertion site that is not relieved by pressure.
- Remember to go for your post-insertion blood work, see below.
- Most women will need re-insertion of their pellets 3-4 months after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. Or you may make your next appointment before you leave today. The charge for the second visit will be only for the insertion and not a consultation unless you would like to discuss treatment and additional hormonal health matters.

Reminders:

Please have your labs rechecked:

( ) 4-6 weeks after your insertion

( ) Every 6 months

( ) Every 12 months

Prescriptions:

( ) DIM _____	Every _____
( ) Thyroid _____	Every _____
( ) Vitamin ADK _____	Every _____
( ) Iodine _____	Every _____
( ) Other _____	Every _____
( ) Other _____	Every _____
( ) Other _____	Every _____

_____ _____

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WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- **SWELLING OF THE HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

- **UTERINE SPOTTING/BLEEDING**: This may occur in the first few months after an insertion, especially if your progesterone is not taken properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

- **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.

- **FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

- **HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

- **HAIR GROWTH**: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

_____ _____

Patient Signature **Today's Date**