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Dr. Tad Connine, Medical Director

# Female Hormone Replacement Therapy Packet

# Patient Demographics

| | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | | M.1. |
| D.O.B. | GENDER: | MARITAL STATUS: | |
| SOCIAL SECURITY NO.: | | PREFERRED LANGUAGE: | |
| RACE: | | | ETHNICTY: |
| HOME ADDRESS: | | | |
| CITY: | STATE: | | ZIP: |
| PHONE #1: | | PHONE #2: | |
| EMAIL: | | | |
| EMPLOYER: | | WORK PH: | |
| ALLERGIES (Medical Alert): | | | |
| | | | |
| PRIMARY CARE PHYSICIAN: | | PHONE: | |
| REFERRING PHYSICIAN: | | PHONE: | |
| PHARMACY NAME: | | PHONE: | |
| ADDRESS: | | | |
| CITY: | STATE: | | ZIP: |
| IN CASE OF EMERENCY CONTACT: | | | |
| FIRST NAME: | | LAST NAME: | |
| RELATION | | PHONE | |
| INSURANCE INFORMATION - PRIMARY | | | |
| Insured Name: | Relationship to Patient: | | DOB: |
| Insurance Company: | | PHONE: | |
| Insurance Company Address: | | | |
| CITY: | STATE: | | ZIP: |
| Policy No. | Group No. | | Employer: |
| INSURANCE INFORMATION - SECONDARY | | | |
| Insured Name: | Relationship to Patient: | | DOB: |
| Insurance Company: | | PHONE: | |
| Insurance Company Address: | | | |
| CITY: | STATE: | | ZIP: |
| Policy No. | Group No. | | Employer: |

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Padgett Medical Center, LLC. I assign and authorize payments to the Padgett Medical Center. LLC, I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I. am responsible for fees not paid in full copayments and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

*I give permission to leave phone message(s):* _____*YES* _____*NO*

_____ _____

Patient and or/Guardian Signature Date

# Padgett Medical Center - Female Packet

**Patient Name:** _____ **Date of Birth:** _____

## Medication History

List ALL medications: prescription, over-the-counter, supplements, and vitamins.

| MEDICATION | DOSAGE | DOSING SCHEDULE |
|---|---|---|
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## Allergies

List all allergies and reactions. (including medications, substances, seasonal, etc.)

| ALLERGY | REACTION |
|---|---|
| | |
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| | |

## Family History

List all illnesses (heart disease, stroke, diabetes, hypertension, cancer – type, etc.)
If a family 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, this information is strictly confidential.
It will be used **only** to address your symptoms and/or complaints.

Do you smoke cigarettes? _____Currently _____Past History _____Never
If yes, how many per day? _____ How long have you smoked, total? _____

Do you drink alcohol? _____Currently _____Past History _____Never
If yes, how of each type do you have in an average week?
Beer: _____ per week Wine: _____ per week Spirits: _____ per week
How long have you been drinking, in total? _____

Do you use illicit drugs (marijuana, cocaine, amphetamines, non-prescribed opiates or narcotics, LSD/acid, etc.)?
_____Currently _____Past History _____Never
If currently or in the past, list the substances used, and how often they are/were used.

_____

_____

_____

_____

## Gynecological History

Last PAP smear: Date: _____
Physician Name:_____ Ph#: _____
Have you ever had an abnormal PAP? _____ YES _____ NO
If yes, what was the abnormality and what follow-up did you have? _____

_____

Last Mammogram: Date: _____
Physician/Facility Name:_____ Ph#: _____
Have you ever had an abnormal mammogram? _____ YES _____ NO
If yes, what was the abnormality and what follow-up did you have? _____

_____

Have you ever had a breast biopsy? _____ YES, Date: _____ _____ NO
If yes, what was the result, and what follow-up did you have, if any? _____

_____

Have you ever had a cervical biopsy? _____ YES, Date: _____ _____ NO
If yes, what was the result, and what follow-up did you have, if any? _____

_____

Have you noticed breast skin or nipple changes? _____ YES _____ NO

Have you noticed any lumps in your breasts? _____ YES_____ NO

Are you using a birth control method? _____ YES _____ NO
If yes, what kind? _____

Are you still having menstrual periods? _____ YES _____ NO
If yes, when was the first day of your last period? _____

Please describe any problems you have with your periods: _____

_____

_____

Periods are: Regular irregular painful crampyheavy 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 _____ UNSURE

Do you have a history of any of the following cancers? Circle those which apply to you. _____ NONE APPLY

Breast Cervix Colon Fallopian Tube Ovary Uterus Vagina Vulva

Other _____

## Hormone Therapy History

Have you been treated with any hormone replacement therapy? _____ YES _____ NO
If yes, give type, reason, and periods of treatment.

| HORMONE | DOSE | REASON | START DATE | STOP DATE |
|---|---|---|---|---|
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## Estrogens

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

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

## Androgens

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

| Androgen Excess | Androgen Deficiency | |
|---|---|---|
| ☐ Acne | ☐ Aches/Pains | ☐ Headaches |
| ☐ Anxious | ☐ Anxious | ☐ Heart Palpitations/Arrhythmia |
| ☐ Breast Cancer | ☐ Apathy/Decreased Passion for Life | ☐ Irritable |
| ☐ Elevated Triglycerides | ☐ Bone Loss | ☐ Low Libido |
| ☐ Increased Body Hair | ☐ Decreased Muscle Mass | ☐ Memory Lapses |
| ☐ Increased Facial Hair | ☐ Depressed | ☐ Sleep Disturbances |
| ☐ Irritable | ☐ Fatigue | ☐ Thinning Skin |
| ☐ Nervous | ☐ Fibromyalgia | ☐ Urinary Incontinence |
| ☐ Oily Skin | ☐ Foggy Thinking | ☐ Vaginal Dryness |
| ☐ Ovarian Cysts | | |
| ☐ Prostate Problems | | |
| ☐ Sleep Disturbances | | |

## Adrenals

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

| Cortisol Excess | | Cortisol Deficiency |
|---|---|---|
| ☐ Acne | ☐ Increased Facial Hair | ☐ Aches/Pains |
| ☐ Anxious | ☐ Loss of Muscle Mass | ☐ Allergies |
| ☐ Bone Loss | ☐ Low Libido | ☐ Apathy/Decreased Passion for Life |
| ☐ Breast Cancer | ☐ Memory Lapses | ☐ Arthritis |
| ☐ Elevated Triglycerides | ☐ Nervousness | ☐ Chemical Sensitivity |
| ☐ Fatigue | ☐ Sleep Disturbances | ☐ Cold Body Temperature |
| ☐ Hair Loss | ☐ Stress | ☐ Exhaustion/Fatigue |
| ☐ Headaches | ☐ Sugar Cravings | ☐ Heart Palpitations |
| ☐ Heart Palpitation/Arrhythmia | ☐ Thinning Skin | ☐ Irritable |
| ☐ Irritable | ☐ Weight Gain – Waist | ☐ Stress |
| ☐ Increased Body Hair | | ☐ Sugar Craving |

## Thyroid

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

| Thyroid Excess | Thyroid Deficiency | |
|---|---|---|
| ☐ Diarrhea | ☐ Aches/Pains | ☐ Inability to Lose Weight |
| ☐ Difficulty Conceiving/Infertility | ☐ Coarse Dry Skin | ☐ Lack of Motivation |
| ☐ Heart Palpitations/Arrhythmia | ☐ Cold Body Temperature | ☐ Muscle Cramps |
| ☐ Heat Intolerance | ☐ Cold Intolerance | ☐ Muscle Weakness |
| ☐ Insomnia | ☐ Constipation | ☐ Stress |
| ☐ Irritable | ☐ Fatigued/Weakness | ☐ Unexplained Weight Gain |
| ☐ Nervousness/Anxious/Panic Attacks | ☐ Hair Loss | ☐ Voice Has Become Hoarse |
| ☐ Tremors/Shakiness | | |
| ☐ Weight Loss | | |

**System Review -** Check the appropriate box for each question.

| Constitutional/ID/Oncology | Yes | No | Not Sure |
|---|---|---|---|
| Have you had unexplained weight loss? | | | |
| Do you have fever and chills? | | | |
| Do you have night sweats? | | | |
| Do you notice swollen lymph nodes? | | | |
| Have you ever been diagnosed with cancer? | | | |
| Have you ever tested positive for HIV? | | | |
| Have you ever had a sexually transmitted disease? | | | |
| | | | |
| **Respiratory** | **Yes** | **No** | **Not Sure** |
| 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? | | | |
| | | | |
| **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? | | | |
| Do you have vascular disease or artery blockages/aneurysms? | | | |
| Have you ever been diagnosed with any heart condition? | | | |
| Have you ever been diagnosed with a blood clot? | | | |
| | | | |
| **Gastrointestinal** | **Yes** | **No** | **Not Sure** |
| 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? | | | |

| **System Review Continued -** Check the appropriate box for each question. | | | |
|---|---|---|---|
| **Endocrine** | **Yes** | **No** | **Not Sure** |
| Do you urinate frequently or 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** | **Yes** | **No** | **Not Sure** |
| Do you have muscle weakness? | | | |
| Have you ever had a seizure? | | | |
| Have you ever fainted? | | | |
| Have you experienced double vision of blind spots? | | | |
| Have you ever been diagnosed with a stroke? | | | |
| | | | |
| **Urologic/Renal** | **Yes** | **No** | **Not Sure** |
| 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 kidney problems? | | | |

## Past Medical History

List any medical problems or illnesses you have had or have.
Include any hospitalizations and accidents with approximate dates.

| Date | Medical Diagnosis, Illness, Accident, etc. |
|---|---|
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## Past Surgical History

List any surgeries, and the dates they were performed.

| Date | Surgery Description |
|---|---|
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**Present Symptoms**

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

_____

_____

_____

_____

_____

Physician Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

# Disclosure/Liability Waiver
# Padgett Medical Center, LLC – Bio-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. Within the medical community, there are opposing. views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones 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 the 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 Padgett Medical Center, LLC, it's 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 it is a release of liability.

I accept all terms and conditions of this program.

| | |
|---|---|
| Signature of Patient | Today's Date |
| Printed Name of Patient | Date of Birth |