Hormone Therapy Questionnaire

(ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL, WILL BE PROTECTED TO THE HIGHEST OF HIPAA STANDARDS, AND WILL BECOME PART OF YOUR NDWC MEDICAL RECORD.)

Name (First, M.I., Last) ______________________________

E-mail ______________________________ SSN ________ - ______ - ________

Address (street) ______________________________

(city) ______________________ (state) __________ (zip) __________

Phone (work) ______________________ (cell) ______________________

(fax) ______________ Occupation ______________________________

Date of birth __________ Gender: ☐ Male ☐ Female Height ________ Weight ________

Primary Physician (name) ______________________ Phone ______________

Date of last physical with your physician ____________ Results ______________

LIFESTYLE	**YES**	**NO**	
Do you smoke?	☐	☐	If yes, how much per day ______________
Do you drink alcohol?	☐	☐	If yes, how much per day ______________
Do you drink caffeine?	☐	☐	If yes, how much per day ______________
Do you exercise?	☐	☐	If yes, please describe ______________

FAMILY HISTORY **age; significant health issues**

Father ______________________________

Mother ______________________________

Brothers/Sisters ______________________________

PERSONAL MEDICAL HISTORY

Previously or currently diagnosed medical conditions ______________________________

____

____

____

____

Surgeries ____

____

Current medications (Name, dosage, frequency) ______________________________

____

____

____

Medication or food allergies, and reaction __________________________________

____

Current vitamins and supplements ____

____

____

____

HRT/TESTOSTERONE TREATMENT CHECKLIST

	YES	NO		YES	NO
Decreased sense of well-being	☐	☐	Thinning or loss of hair	☐	☐
Difficulty sleeping	☐	☐	Heat or cold intolerance	☐	☐
Decreased energy	☐	☐	Decreased skin tone	☐	☐
Decreased concentration, memory	☐	☐	Mood swings	☐	☐
Decreased sex-drive	☐	☐	Sadness, depression	☐	☐
Decreased muscle strength	☐	☐	Hot flashes	☐	☐
Increased fat deposits	☐	☐	Prolonged exercise healing	☐	☐

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<u>MEN</u> ONLY

How many times do you empty your bladder at night? ________Has this changed in the last 12 months? __________

Do you have problems with erectile dysfunction or ejaculation? ____

Have you had a kidney, bladder or prostate infection in the last 12 months? __________________________________

Do you have blood in your urine? _______________ Date and result of last PSA test __________________________

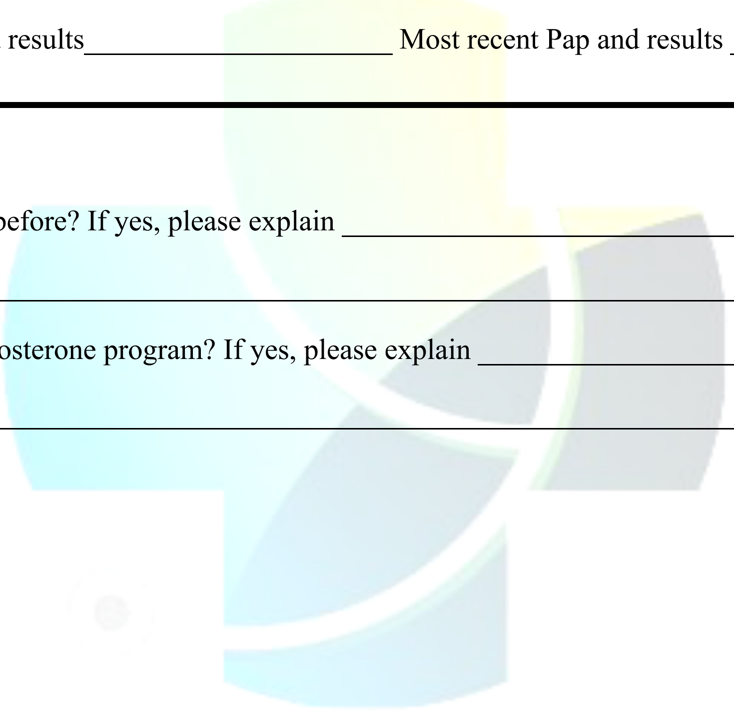
<u>WOMEN</u> ONLY

Date of last menses___________________ Number of pregnancies __________ Number of live births ____________

Are you pregnant or breast-feeding? _________________ Type of birth control _______________________________

What are your main PMS symptoms? ____

Most recent mammogram and results_____________________ Most recent Pap and results _____________________



Have you ever been on HRT before? If yes, please explain ____

____

Have you ever been on a Testosterone program? If yes, please explain _______________________________________

____

PATIENT AGREEMENT FOR TREATMENT

DFW Anti-Aging and Wellness Centers is an Insurance Free Entity.

THIS AGREEMENT is made and executed on ____ (day) of ___________ (month) 2018, between DFW Anti-Aging and Wellness Centers (hereafter called "DFWAAWC") and ____ (hereafter called "Patient").

IN CONSIDERATION of DFW Anti-Aging and wellness centers providing Patient with medical management, administrative, and follow-up services, Patient understands and agrees to the following:

Patient understands that he/she will not request DFWAAWC to submit a claim to any third party payor, even if patient is entitled to benefits, for any portion of the fee or any services rendered to patient. DFWAAWC will not accept assignment from any third party payor as payment for services. **Patient understands that Medicare, Medicaid, and Champus require a waiver that states the patient acknowledges the waiving of rights to file a claim to seek reimbursement from these entities or secondary insurance coverage. _____**

MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire or to the Physician(s) of DFWAAWC could result in inappropriate treatment. _____

AUTHORIZATION: Patient authorizes DFWAAWC to obtain, on Patient's behalf, medical laboratory, diagnostic testing, Physician(s) consulting, and compounding pharmacy supplies. In addition, Patient authorizes DFWAAWC and the Physician(s) to provide medical care and prescribed pharmaceuticals based on the Medical History Questionnaire, laboratory testing, and other information submitted to DFWAAWC under this agreement. _____

INSTRUCTIONS AND TREATMENT: Patient understands and agrees to comply with the method of instruction, treatment and dosage schedules prescribed by Physician(s); to immediately cease any medical treatment prescribed by Physician(s) in the event of an adverse reaction or side effect arising from prescribed treatment; and to immediately provide and DFWAAWC Physician(s) with written notice *via email to Wellnessdir@dfwantiagingwellness.com* of any such adverse reaction or side effect. Patient understands and agrees that diagnosis and treatment of any medical condition may involve certain risk. _____

PRIMARY CARE PHYSICIAN: *Patient represents that he or she is under the care of a primary care Physician* and that Patient will not rely or substitute the advice of DFWAAWC Physician(s) should it conflict with the advice of the Patient's primary care Physician. Patient agrees to notify his or her primary care Physician that Patient is receiving HRT. _____

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LABORATORY FEES: DFWAAWC will obtain laboratory testing from certified and registered labs in Texas, including QuestLab and LabCorp. DFWAAWC will assist the patient in filing laboratory fees to patient's insurance for reimbursement. However, patient understands and agrees that patient's insurance coverage may involve co-pays and/or deductibles, which may require patient to be financially responsible for laboratory fees. _____

HORMONE REPLACEMENT THERAPY: Patient understands and agrees that, although each hormone has been approved by the FDA, the FDA only approves or denies usage of products made by manufacturers which are produced in a specific dosage and form. Therefore, the FDA does not approve or disapprove of hormones which are given in an individual dosage or form for each patient by Physician(s) of DFWAAWC. I also understand that Physician(s) may choose to discuss with me and provide medications that are off-label in order to offer the widest range of therapies possible. Off-label prescribing is a common and legal practice by most physicians in the US whereby medications are prescribed for purposes other than originally approved. _____

WARRANTY: Patient understands and agrees that the methods of medical treatment offered by DFWAAWC and Physician(s) are not accompanied by any claims, guarantees, or warranties. This agreement remains in effect until revoked by Patient in writing, and photocopies of this assignment shall be construed as valid as the original. _____

EMAIL COMMUNICATION: Patient understands and agrees that DFWAAWC offers communication via email for non-urgent matters such as lab results. Although DFWAAWC has implemented reasonable technical safeguards, DFWAAWC cannot guarantee privacy, security, or confidentiality of emails sent or received. DFWAAWC is not responsible for emails that are lost due to technical failure during composition, transmission, or storage. DFWAAWC will not forward emails to third parties without your prior written consent, except as authorized or required by law. Until new technologies are adopted by DFWAAWC, patient understands and agrees that email communications are not encrypted. DFWAAWC RESPECTS AND PROTECTS THE PRIVACY OF OUR PATIENTS. DFWAAWC WILL NEVER SELL OR RENT YOUR EMAIL ADDRESS TO THIRD PARTIES. **You may discontinue receiving emails as a means of communication by sending an email or letter to *DFWAAWC*. _____**

RESCHEDULING: If patient needs to reschedule or cancel appointment, he/she agrees to notify *DFWAAWC within 24 hours* of scheduled appointment. Patient understands that failure to do so, regrettably, will result in a $100 "no-show" fee. _____

________________________________ ________________________________

Patient Printed Name Patient Signature