Female BHRT Medical History Form

Chantel Unseld, APRN
Skin Deep Rejuvenation Center
502.275.9391 office

Patient Info **Date: _____**

Name_____
First Middle Last

Address_____

City_____ State_____ Zip _____

Phone_____ Email_____

Height_____ Sex M/F Social Security #_____

DOB_____ Age_____ Marital Status_____

Employer/Occupation _____

Phone _____

Office Use Only
Weight_____
BMI_____
BP_____
P _____

Allergies:_____

Medications, OTC, Vitamins:_____

_____

Medical Conditions/Diseases (Please check all that apply)

_____Heart disease - Type:_____ ____Lung Disease ____Cancer-Type_____

____High cholesterol or lipids
____Ulcers ____Diabetes

____High blood pressure
____Arthritis or joint problems ____Depression

____Thyroid disease ____Headaches/migraines ____Endometriosis

____Liver disease ____Persistent urinary tract infection ____Fibrocystic breast

____Osteoporosis
____Abnormal vag bleeding ____Stroke

____Uterine Fibroids/Ovarian Cysts ____Blood clots (ie, DVT,PE) ____PMS/PMDD

____ Heart Attack or Heart Blockage _____Other- Please list

Do you have a FAMILY history of any of the following?

	Yes	No	Family Member(s)
Uterine Cancer	▫	▫	_____

Ovarian Cancer	☐	☐	_____
Breast Cancer	☐	☐	_____
Colon Cancer	☐	☐	_____

Name_____
First **Middle** **Last**

Have you had any of the following procedures/exams?

	Yes	No	Date
Hysterectomy (uterus)	☐	☐	_____
Oophorectomy (ovaries)	☐	☐	_____
Tubal Ligation	☐	☐	_____
Sexually transmitted infection	☐	☐	_____

Have you had any of the following?

	Yes	No	How many?
Pregnancies	☐	☐	_____
Miscarriages	☐	☐	_____
Children	☐	☐	_____

Do you use any of the following?

	Yes	No	If **yes**, how often and how much
Alcohol	☐	☐	_____
Tobacco	☐	☐	_____
Soy	☐	☐	_____
Caffeine	☐	☐	_____
Other	☐	☐	_____

Have you had any of the following exams?

	Yes	No	Date/Result / Physician
Mammography	☐	☐	_____ Please provide a copy

PAP smear	□	□	_____ Please provide a copy
Pelvic Ultrasound	□	□	_____
Bone Density Scan	□	□	_____

Name_____
First **Middle** **Last**

Please answer the following questions

	Yes	No	How many?
Do you plan to have more children?	□	□	_____
Are you currently breastfeeding?	□	□	_____
Are you currently pregnant?	□	□	_____
Are you currently sexually active?	□	□	_____

List any surgeries previously not listed: Approx Date

_____

_____

Please answer the following questions

Sleep difficulties Y N Sleep_____hrs/ night

Difficulty falling asleep _____ Staying asleep _____

How would you describe your quality of sleep Poor Fair Good Great

Do you exercise?

□Yes □No

If yes, please describe your routine. _____

Do you currently follow a special diet? □Yes □No

If yes, please explain. _____

List out a typical breakfast lunch and dinner _____

_____

How would you rate your stress on a scale of 1-10 (10 being the highest _____

Have you ever used hormone replacement therapy? □Yes □No

If yes, please list medications, dose, directions, and duration _____

Did you have any problems? If yes, please explain. _____

Name_____
First **Middle** **Last**

Please answer ONLY if you are still having your menses

What form of birth control do you use now? _____

Date of last period _____

How many days does your period last? _____

Do you have heavy cycles? oYes oNo

If yes, please explain _____

Do you have regular cycles? oYes oNo

If no, please explain _____

How many days is your menstrual cycle? _____

What are you top three goals for starting Hormone Replacement therapy?

1._____

2._____

3._____

I agree that I answered the above information to be true and to the best of my ability and

I know that the answers given will directly reflect the care that will be chosen for me.

_____

Patient Signature Date

Witness Signature Date

06/2020

Skin Deep Rejuvenation Center

HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguard to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of you Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

We have adopted the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers as necessary and appropriate for your care. Patient files may be stored in open files racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available persons other than office staff. You agree to the normal procedures utilized with in the office for than the handling of charts, client records, PHI and other documents or information.
2. It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, US mail, text, or any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology, as well as our office promotional material that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider.
6. We agree to provide client's access to their records in accordance with state and federal laws.

7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information form any subsequent changes in office policy. I understand that this consent shall remain in force from the is time forward.

CLIENT RIGHTS AND RESPONSIBILITY

We believe that a confidential, mutually respectful partnership between Healthcare Clinicians/Providers and Clients/Patients is the best way to develop and maintain optimal health.

Client/Patient rights including the right to privacy, the right to be treated with respect, consideration and dignity, the right to confidentiality of health care information, the right to be provided with complete information, the right to participate in health care decision making including the right to consent to or refuse treatment, the right to request treatment in his/her native language through a translator or other resources, and the right to select a Healthcare Provider whenever possible.

Clients/Patients have the right to know the names, titles and qualification of staff members serving them and to request a chaperone during an procedures.

Clients/Patients have the right to expect privacy and confidentiality, including from parents, professors, and potential employers; Client/Patient information is not disclosed without written permission except, upon court order, as required by law (as in the case of certain communicable diseases and for reports of child abuse), or as required in our judgment to protect the Client/Patient or others from physical danger.

Clients/Patients have the right to have information about the operations and services of Health Services, including the hours that services are available and current fees and payment policies.

Clients/Patients have the right to be informed about procedures for giving feedback on services including how to make a suggestion or how to make a formal complaint.

Our office expects Clients/Patients to responsibly participate as active members of the healthcare team, provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities, ask questions in order to understand and follow healthcare advice and medical instructions, respect the policies of Health Services.

_____

PATIENT SIGNATURE DATE

Patient Name_____

DOB:_____ Phone Number _____

ESTROGEN DEFICIENCY	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Memory Loss/Lapse	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Urinary Tract Infections	_____	_____	_____	_____
Increase in urinary urge	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Yeast Infections	_____	_____	_____	_____
Vaginal Dryness/Atrophy	_____	_____	_____	_____
Headaches	_____	_____	_____	_____

ESTROGEN EXCESS

Swelling of ankles or wrists	_____	_____	_____	_____
Breast Swelling/Tenderness	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Uterine Fibroids	_____	_____	_____	_____
Nervousness/Anxiety/Irritability	_____	_____	_____	_____
Heavy/Irregular Menses	_____	_____	_____	_____
Cravings for Sweets	_____	_____	_____	_____

Patient Name_____

DOB:_____ Phone Number _____

PROGESTERONE DEFICIENCY	Absent	Mild	Moderate	Severe
PMS Symptom	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Swollen or Tender Breast	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Acne/oily skin	_____	_____	_____	_____
Infertility	_____	_____	_____	_____
Inflammation	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____

LOW THYROID FUNCTION

Fatigue (Especially Evening)	_____	_____	_____	_____
Cold Extremities	_____	_____	_____	_____
Intolerance to Cold	_____	_____	_____	_____
General Aches and Pains	_____	_____	_____	_____

Depression	_____	_____	_____	_____
Dry Skin	_____	_____	_____	_____
Swollen Puffy Eyes	_____	_____	_____	_____
Poor Concentration	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Brittle or breaking nails	_____	_____	_____	_____
Lack of Motivation/Stamina	_____	_____	_____	_____
Decreased Sweating	_____	_____	_____	_____

Patient Name_____

DOB:_____

LOW THYROID FUNCTIONcont	Absent	Mild	Moderate	Severe
Thinning Hair	_____	_____	_____	_____
Sleep Disturbances	_____	_____	_____	_____
Elevated Cholesterol	_____	_____	_____	_____
Goiter	_____	_____	_____	_____

INCREASED THYROID FUNCTION

Weight Loss	_____	_____	_____	_____
Excessive sweating	_____	_____	_____	_____
Loose stools or diarrhea	_____	_____	_____	_____
Heat intolerance	_____	_____	_____	_____
Chest pain	_____	_____	_____	_____
Light or Absent Menses	_____	_____	_____	_____
Puffiness Around Eyes	_____	_____	_____	_____
Starring gaze	_____	_____	_____	_____

TESTOSERONE DEFICIENCY

Fatigue Prolonged	_____	_____	_____	_____
Memory Problems	_____	_____	_____	_____
Less Self Confident/More Hesitant	_____	_____	_____	_____
Tire Easily with Physical Activity	_____	_____	_____	_____
Muscle Weakness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Thinning Skin	_____	_____	_____	_____

TESTOSTERONE EXCESS

Acne	_____	_____	_____	_____

Patient Name_____

DOB:_____

	Absent	Mild	Moderate	Severe
TESTOSTERONE EXCESS cont				
Deepening of Voice	_____	_____	_____	_____
Clitoral Enlargement	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Irritability/Moody/Aggressiveness	_____	_____	_____	_____
Loss of scalp hair or thinning	_____	_____	_____	_____
LOW CORTISOL				
Cravings for salt, stimulants (sugar, caffeine, nicotine, carbs)	_____	_____	_____	_____
Mental Fatigue	_____	_____	_____	_____
Allergies (new onset)	_____	_____	_____	_____
Apathy	_____	_____	_____	_____
Chemical sensitivities	_____	_____	_____	_____
Poor memory/Concentration	_____	_____	_____	_____
Decreased stamina	_____	_____	_____	_____

Decreased Ability to Handle Stress	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Low Blood Pressure	_____	_____	_____	_____
Low Pulse	_____	_____	_____	_____
Digestive Problems	_____	_____	_____	_____
Decreased Sexual Interest	_____	_____	_____	_____
Decreased immune function/incr infections	_____	_____	_____	_____
Heartburn (New onset)	_____	_____	_____	_____

Patient Name_____

DOB:_____

	Absent	Mild	Moderate	Severe
HIGH CORTISOL				
same as low but including				
Sleep Disturbances	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Inflammation	_____	_____	_____	_____
Nervousness/Irritability	_____	_____	_____	_____
Foggy thinking	_____	_____	_____	_____
MELATONIN				
Rapid Aging	_____	_____	_____	_____
Have trouble falling asleep at night	_____	_____	_____	_____
Wake up During the Night	_____	_____	_____	_____
Once awake can't fall back to sleep	_____	_____	_____	_____
I can't turn my mind off when I try to sleep	_____	_____	_____	_____
I wake up and don't feel rested	_____	_____	_____	_____

Morning Fatigue _____ _____ _____ _____

Name your top 3 Symptoms or Concerns you are having

1._____

2._____

3._____

Name any symptoms not listed above that are concerning for you

_____

_____

Patient Signature

06/2020 cu

Chantel Unseld, APRN

Skin Deep Rejuvenation
502.275.9391

BIO-IDENTICAL HORMONE THERAPY CONSENT

Member Name_____ **Date of Birth**:_____+_____

I request and consent to the administration of hormone replacement therapy (HRT), which may consist of Testosterone, Estradiol, Progesterone and other bio-identical hormones prescribed.

I understand that I may be in charge of administering these hormones and supplements prescribed to myself. I will conform and comply with the recommended doses and methods of administration.

I understand that natural or bioidentical hormone replacement therapy (BHRT) is the therapeutic use of hormones identical to the hormones made naturally by the body. These hormones are typically used to treat symptoms of PMS, pre-menopause, peri-menopause, menopause, post-menopause, andropause (male menopause), thyroid dysfunction and adrenal fatigue. Other symptoms and health concerns may also be treated with BHRT. The nature of the procedure is to raise levels of hormones in my body to a healthy range for the purpose of symptom relief and long-term health.

I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone level. I agree to communicate with Chantel Unseld, APRN concerning any adverse reaction or problems that I experience.

I understand that bioidentical estrogen potentially has the same cancer risk as the estrogen produced within my own body and should never be used without bioidentical progesterone. Personal family history of breast,

ovarian, or endometrial (uterine) cancer should be discussed with your healthcare provider. For male patients, studies have shown testosterone does not increase risk of prostate cancer. Although some studies have shown an increased risk of heart attack and stroke with Testosterone Replacement Therapy, a large majority of studies show improved heart health, and decreased risk.

I understand that Estriol is the protective estrogen, thought to reduce the risk of breast cancer or recurrence. Estriol is a much safer form of estrogen because it isn't metabolized into other hormones, keeping its unique identity. Estriol does not stimulate growth of breast tissue in physiologic doses.

I understand that BHRT does not increase heart disease if given at the proper dosage and ratio. Patients with previous deep vein thrombosis (DVT), or blood clots, require careful monitoring if they are taking oral estrogen. Women or men with known heart disease or other serious illness need routine evaluation and annual labs including cholesterol levels, EKG, and other necessary tests. Patients are encouraged to follow up with their primary care physician for these conditions. BHRT taken transdermally (through the skin) does not increase risks of blood clots or DVT.

I understand the possible side effects that can occur, including the following: I understand that careful surveillance and close monitoring are required of all patients to minimize any possible risk.

I agree to regular salivary or blood spot testing of my hormone levels to aid Chantel Unseld in the ability to make corrections or adjustments as needed if this was necessary.

WOMEN: Bio-identical estrogens are available in various forms including oral capsules, troches, patches, pellets and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, and mood swings. **Hormone therapy should be discontinued immediately if you become pregnant. Please inform us if you are planning to become, or do become pregnant.**

PROGESTERONE therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

TESTOSTERONE Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur.

MEN: Possible side effects include but are not limited to moodiness, irritability, anxiety and restlessness, and palpitations. Hormone therapy has the potential to cause a current prostate cancer to grow more rapidly therefore, a prostate-specific antigen blood test is conducted throughout the duration of hormone therapy. Testosterone may also increase a hemoglobin and/ or hematocrit count, or thickened blood. This is easily reversed by periodically donating blood or by withholding injections until levels are satisfactory. Testosterone may decrease sperm count. Please consider this is you are planning to have children. Your provider may discuss other options with you.

Statement of Patient:

I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the

administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I understand that it is my responsibility to have an annual physical examination, annual gynecological exam/ breast exam/mammogram or equivalent (for males, i.e. prostate exam), including any suggested laboratory tests to ensure that I have no disease(s) which might make natural BHRT inappropriate for my condition.

I understand that the role of the provider, Chantel Unseld, APRN is for hormone therapy only and that she is not responsible for diagnosis of underlying medical conditions that may affect my response to treatment.

I authorize that I am under the regular care of my primary care physician for all other medical conditions and will consult them for any other medical services I may require.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure except as the claim pertains to negligent administration of the procedure.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that Hormone Therapy for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I certify this form has been fully explained to me, that I have read it or have had it read to me and I understand its contents. I agree to the therapy described above. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

Initial consult for new patient 55-60 min, $175

Transfer pt from another hormonal office $125

Follow-Up Appointments $75

Please note these fees will not include the cost of labs or prescriptions that you may be required to obtain in order to make the most appropriate plan for you.

You are welcome to run blood tests through your insurance OR if you feel your coverage is poor we can provide you a self pay price through our office that must be paid in full before lab order is given. At this point we will provide you codes that you can attempt to file with your insurance for reimbursement.

Labs fees through ZRT will need to be performed if you are using creams due to this is the only appropriate way to determine if your dose is safe for you.

Payment is required at the time of service. We do not participate with any insurance plans.

As we understand schedules can change we would appreciate you taking every step to keep your appt time that we have given you.

_____

Signature Date

Print Name

Witness Date

6/2020