NovaHealth
Natural Hormone Replacement Therapy

Patient Information-Female

Name:_____ Today's Date:_____

Date of Birth:_____ Present Weight:_____

Street Address: _____

City:_____State:_____Zip:_____

Phone-Home:_____Cell: _____

Email:_____

Patient employed by: _____

Business Address:_____

Business Phone:_____

Marital Status: (Please Circle) Married Single Divorced Widow

Spouse/Significant Other Name:_____

Spouse/Significant Other Phone:_____

In case of an emergency, whom shall we notify:_____

Phone:_____

Signature:_____Date:_____

I understand that this consultation may be recorded for training purposes only-Initial here:_____

Revised 1/2016

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Symptoms Questionnaire

Patient Name:_____ Date:_____

Please circle one of the following categories below to let us know how you are feeling at today's appointment:

Current Status- What are your CURRENT symptoms?

0 means you have **no symptoms** of this type at all / **1** means you have **very mild symptoms** of this type / **5** means you have **moderate symptoms** of this type / **10** means you have **severe symptoms** of this type.

(P)	Low_____ Moderate____ Severe___											Comments, if any
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	_____
Irritability	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety	0	1	2	3	4	5	6	7	8	9	10	_____
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Palpitations	0	1	2	3	4	5	6	7	8	9	10	_____
(E)												
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10	_____
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Loss	0	1	2	3	4	5	6	7	8	9	10	_____
(T)												
Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Weight Control	0	1	2	3	4	5	6	7	8	9	10	_____
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Body-Joint Pains	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	_____
↓ Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	_____

Patient Comments or any changes in medical conditions or medications since last report:

_____

_____

_____

Patient Signature:_____ Date:_____

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Patient Name:_____
Date of Birth:_____

Medical History

1.	Do you have diabetes?	Yes	No
2.	Do you have hypertension?	Yes	No
3.	Do you have heart disease?	Yes	No
4.	Do you have a heart murmur?	Yes	No
5.	Do have/had kidney disease?	Yes	No
6.	Have you ever been treated for psychiatric problems?	Yes	No
7.	Have you had rheumatic fever?	Yes	No
8.	Do you have mitral valve prolapse?	Yes	No
9.	Have you ever been diagnosed with or treated for cancer?	Yes	No
10.	Have you ever had a urinary tract infection?	Yes	No
11.	Have you ever had hepatitis/liver disease?	Yes	No
12.	Have you had varicosities/phlebitis?	Yes	No
13.	Do you have a thyroid problem?	Yes	No
14.	Have you had any major accidents?	Yes	No
15.	Have you had a blood transfusion?	Yes	No
16.	Do you have asthma/lung disease?	Yes	No
17.	Do you have lupus?	Yes	No
18.	Do you have arthritis?	Yes	No
19.	Do you have any drug allergies?	Yes	No
20.	Do you have diverticulitis?	Yes	No

21. Please list all medications that you are currently taking including any Hormone Replacement Therapies:_____
_____
_____

22. Please list any medications to which you are allergic: _____
_____

23. Please list any surgeries or hospitalizations: _____
_____

24. Other medical history for yourself or family:_____
_____

Patient Initials:_____

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Date of Birth:_____

Medical History-continued

25. Have you had a hysterectomy?_____
26. Are you pregnant?_____ Are you planning to become pregnant?_____
27. Are you breast feeding? _____
28. How many times have you been pregnant?_____
29. How many miscarriages have you had?_____
30. Have you had any premature deliveries?_____
31. Are you sexually active?_____
32. Do you have pain with intercourse?_____
33. What form of contraception are you currently using? (Circle below)

Pills	Tubal Ligation	Condoms	Withdrawal	Depo Provera
Foam	Vasectomy	Diaphragm	Implants	Other

34. Are you having problems with your method of birth control?_____
35. Date of last pap smear:_____
36. Have you ever had an abnormal pap smear?_____
37. Do you have trouble leaking urine?_____
38. Do you have breast lumps, tenderness or discharge?_____
39. Have you had a mammogram?_____ Date:_____ Was it normal?_____
40. Do you have PMS symptoms?_____
41. Do you have hot flashes or menopausal symptoms?_____
42. Do you have urine anomalies?_____
43. If you no longer have periods, please state reason:_____
44. First day of last period:_____
45. How many days does your period last?_____
46. Are your periods regular?_____
47. How many days from the start of one period to the start of the next period?_____
48. Do you bleed between periods?_____
49. Do you have cramping with periods?_____If yes circle one:**MILD MODERATE SEVERE**
50. Do you smoke cigarettes:_____ If yes, # per day:_____ How many years?_____

Patient Initials:_____

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Informed Consent

I,_____, acknowledge that I have been presented with a copy of the Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorizations before any other disclosures may be made.

Initial:_____ Date:_____

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself, to notify me of my appointment or to tell me the test results are back. We will not lease a test results on your answering machine.

Patient Signature:_____
Date:_____

I request that my protected health information be disclosed to the following persons or facility as listed below:_____
_____
_____
_____

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Notice of Privacy Practices

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agency authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by State and Federal Law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

More Stringent Laws

We will evaluate whether your protected health information is governed by more stringent laws or regulations prior to our use or disclosure. There are other more stringent laws and rules, such as the federal substance abuse confidentiality regulations, the State Medical Health confidentiality statue(s), the State Public Health confidentiality provisions, and State Minor Consent statue(s), governing status (i.e., emancipation, marital status, etc.) or type of treatment (abortion, sexually transmitted disease, birth control, etc.), that may affect how we handle your information.

_____ _____

Signature of Patient (or Legal Representative) Date