Patient Questionnaire (Female)

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

Date of Birth: _____ Age: ____ Occupation: _____ Race: _____ Ethnicity: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? ☐ Patient (Name: _____) ☐ Event (_____)

☐ Practitioner (Name: _____) ☐ Social Media (Type: _____)

☐ Web (Keyword Searched: _____) ☐ Print (Ad seen in: _____)

In Case of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

OBGYN Physician's Name: _____ Phone: _____

Address: _____

MEDICAL HISTORY

Height: _____ Weight: _____ Last Menstrual Period or date of Menopause: _____ Irregular or Regular periods (please circle)

Hysterectomy? ( ) No ( ) Partial ( ) Full Currently Pregnant? ( ) Planning to become Pregnant in the next year? ( )

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____

Any known drug allergies: ( ) Yes ( ) No If yes please explain: _____

Current Medications and dosage: _____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ **Past HRT:** _____

Surgeries, list all and when: _____

Have you ever been diagnosed with PCOS? ( ) Yes ( ) No

Do you have a family history of? ( ) Fibrocystic Breast Disease ( ) Breast Cancer ( ) Other Cancer_____ ( ) Heart Disease

Personal Medical History (Please check all that apply)

Preventative Medical Care:
- ( ) Medical/GYN Exam in the last year.
- ( ) Mammogram in the last 12 months.
- ( ) Bone Density in the last 12 months.
- ( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:
- ( ) Breast Cancer.
- ( ) Fibrocystic Breast Disease.
- ( ) 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.
- ( ) Osteoporosis.
- ( ) Clotting Disorder.
- ( ) 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.
- ( ) Migraines.
- ( ) Cancer Type:_____ Year: _____

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

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MRS Checklist - BEFORE HRT

Name:_____ **DOB:**_____ **Age:** _____ **Date:**_____

Which of the following symptoms apply at this time?
Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes**	☐	☐	☐	☐	☐
2. **Night Sweats** (episodes of sweating)	☐	☐	☐	☐	☐
3. **Vaginal Dryness** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
4. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
5. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
6. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
7. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
8. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
9. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
10. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
11. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
12. **Joint & muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐
13. **Difficulty losing weight despite diet and/or exercise**	☐	☐	☐	☐	☐
14. **Feeling Cold**	☐	☐	☐	☐	☐
15. **Activity Level** (important to determine absorption rate)	☐ High	☐ Moderate	☐ Low		

Please share any additional comments about your symptoms you would like to address.

_____

_____

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EVEXIAS MEDICAL DENVER/DENVER VEIN CENTER

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW CAREFULLY.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

Our Uses & Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- As required for billing insurance for services
- Comply with Law and help with public health and safety issues
- Address workers' compensation law, law enforcement, and other government requests
- Respond to lawsuits and legal actions

PHI Consent

I consent Evexias Medical/Denver Vein to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results, financial services and special offers on the following:
Phone: _____ Voicemail / Text (please circle all that apply)
Email: (Print please)_____

I give consent to Evexias Medical Denver to release my protected health information (PHI) to include but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information to the following people:

Name:_____Phone#:_____

Signature

This consent will expire with the written notification to info@evexiasdenver.com

Signature:_____Date_____

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WHAT MIGHT OCCUR (FOR FEMALES ONLY)

Patient Name:_____**DOB:**_____

A significant hormonal transition will occur in the first 3-6 weeks after beginning your BHRT regime. 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 you have been prescribed progesterone and are not taking 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 THINNING: Is VERY rare and usually occurs in patients who over-convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in these 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.

I acknowledge that I have received a copy and understand the instructions on this form.

_____	_____	_____
Name (Print Legibly)	**Signature**	**Date**