Today's Date: ___/___/____

Female New Patient Information

Name: _____ DOB: _____ Height: _____

Street Address: _____ City/St/Zip: _____

Phone Number: _____ Email: _____ SSN: _____

Occupation: _____ Employer/Title: _____

Work Phone: _____ Work Address: _____

How did you hear about us: _____

Marital Status (Please Circle): Married Separated Divorced Single Widow Living with significant other

Children (Please Circle): Biological Adopted Step Children None

Do you desire more children (Please Circle): Yes No

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____ Address: _____

Primary Care Physician:

Name: _____ Phone Number: _____

Address: _____ City/St/Zip: _____

Preferred Pharmacy:

Name: _____ Phone Number: _____

Address: _____ City/St/Zip: _____

Please List all Current Medications and Doses:

_____/_____

_____/_____

_____/_____

Please list any known drug allergies (or write no known allergies): _____

Are you currently or have you ever used any form of Testosterone or Hormone Therapy:

Please Circle: Never Used Gel Cream Shots Pellets Other

Main Concerns/ Reason for Visit:

- ☐ Fatigue
- ☐ Decreased Libido
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Vaginal Dryness
- ☐ Weight Concerns
- ☐ Mood Concerns
- ☐ Other:_____

Symptom Checklist

Please Circle the Severity of each classification:

Weight Gain:	Yes	No	# of Pounds in a year: _____
Night Sweats:	Yes	No	# of times a day: _____
Hot flashes/ hot flushes:	Yes	No	# of times a day: _____

Fatigue:	Frequently	Rarely	Never
Pain with intercourse:	Frequently	Rarely	Never
Vaginal dryness:	Frequently	Rarely	Never
Sleeping problems:	Frequently	Rarely	Never
Urine leaks:	Frequently	Rarely	Never
Trouble focusing/memory loss:	Frequently	Rarely	Never
Mood swings:	Frequently	Rarely	Never
Migraines:	Frequently	Rarely	Never
Depression:	Frequently	Rarely	Never
Anxiety:	Frequently	Rarely	Never
Decrease in sexual desire:	Frequently	Rarely	Never
Loss of memory:	Frequently	Rarely	Never
Foggy thinking:	Frequently	Rarely	Never
Muscle and/or joint pain:	Frequently	Rarely	Never

GYN History

Age at first menstrual cycle: _____

Age at first child's birth: _____

How many children have you had: _____

Are you pregnant, trying to get pregnant or breastfeeding? Yes No

If No, What type of contraception are you currently using (Please circle below all that apply):

Pills IUD Foam Condoms Diaphragm

Implants Depo Vasectomy Tubal Ligation Other: _____

Do you have a uterus: Yes No

Date of last Mammogram: _____

Was it normal: Yes No

Do you do self-breast exams: Yes No

Do you have any breast lumps, tenderness or discharge: Yes No

Date of last Pap smear: _____

Have you ever had an abnormal pap smear: Yes No

If yes, how was it treated: Cryosurgery Hysterectomy Cone Biopsy Loop Excition

Are you sexually active: Yes No

Do you have pain with intercourse: Yes No

Have you ever had any vaginal, cervical, and or tubal infection: Yes No

If yes, please circle all that apply: Syphilis Yeast PID Herpes

Chlamydia Gonorrhea Warts Other

First day of last period: _____

How many days do your periods last: _____

Are your periods regular: Yes No

Do you have PMS Symptoms: Yes No

Has the flow of your period changed: Yes No If yes, please explain: _____

Does bleeding occur between your normal period cycle: Yes No

Have you had any abnormal bleeding in the past year: Yes No If yes, please explain: _____

If you no longer have periods, please circle the reason:

Natural Hysterectomy Ablation Menopause IUD

If Menopausal, at what age did you start menopause: _____

Do you experience post-menopausal bleeding: Yes No

Medical History

(Do you have or have you had any of the following)

ADHD:	Yes	No	Fibromyalgia:	Yes	No
AIDS/HIV:	Yes	No	GI Problems:	Yes	No
Acid Reflux:	Yes	No	Hair loss:	Yes	No
Acne:	Yes	No	Headaches/Migraines:	Yes	No
Allergies:	Yes	No	Heart attack:	Yes	No
Anemia:	Yes	No	Heart Problems:	Yes	No
Anxiety Disorder:	Yes	No	Hepatitis:	Yes	No
Arthritis:	Yes	No	High blood pressure:	Yes	No
Asthma:	Yes	No	High Cholesterol:	Yes	No
Bladder problems:	Yes	No	High Iron:	Yes	No
Bloating/ Swelling:	Yes	No	Hyperthyroidism:	Yes	No
Blood Diseases:	Yes	No	Hypothyroidism:	Yes	No
Blood transfusions:	Yes	No	Infertility:	Yes	No
Breast Cancer:	Yes	No	Joint problems:	Yes	No
Breast Problem:	Yes	No	Kidney Disease:	Yes	No
Blood Diseases:	Yes	No	Kidney stones:	Yes	No
Cancer:	Yes	No	Leukemia:	Yes	No
If Yes, Please explain: _____			Liver disease:	Yes	No
Colon Cancer:	Yes	No	Lung Disease:	Yes	No
Colon Polyps:	Yes	No	Mental Disorder:	Yes	No
Congestive heart failure:	Yes	No	Muscle Problems:	Yes	No
Constipation:	Yes	No	Osteoporosis:	Yes	No
COPD:	Yes	No	Ovarian Cancer:	Yes	No
Coronary Artery Disease:	Yes	No	Seizures/ Epilepsy:	Yes	No
Depression:	Yes	No	Skin Problems:	Yes	No
Diabetes:	Yes	No	Stroke:	Yes	No
Eating Disorder:	Yes	No	Varicosities:	Yes	No
Eczema:	Yes	No	Water retention:	Yes	No
Endometriosis:	Yes	No	Other: _____		
Fatigue:	Yes	No			

Surgical History

- ☐ Appendectomy
- ☐ Breast Augmentation
- ☐ Colonoscopy
- ☐ Gall bladder removal
- ☐ Hysterectomy
- ☐ Knee surgery
- ☐ Rhinoplasty
- ☐ Tonsillectomy
- ☐ Wisdom teeth removal
- ☐ Other Surgeries: _____

Have you ever had any anesthesia complications: _____ Yes _____ No

If yes, explain: _____

Family History:

(Please Circle Yes/No)

Do you have a family history of breast cancer:	Yes	No	If yes, who: _____
Do you have a family history of colon cancer:	Yes	No	If yes, who: _____
Do you have a family history of ovarian cancer	Yes	No	If yes, who: _____
Do you have a family history of osteoporosis	Yes	No	If yes, who: _____
Do you have a family history of hypertension	Yes	No	If yes, who: _____
Do you have a family history of heart disease:	Yes	No	If yes, who: _____
Do you have a family history of kidney disease:	Yes	No	If yes, who: _____

At what age did your mother go through menopause: _____

Social History

(Please Circle Yes/No)

Have you ever smoked cigarettes: Yes No Do you currently smoke cigarettes: Yes No

If yes, how many on average per day: _____ How many years have you been smoking: _____

Do you use recreational drugs: Yes No If yes, please explain: _____

Do you drink alcohol: Yes No If yes, how many drinks do you average a week: _____

Do you exercise: Yes No

Do you consume caffeine: Yes No

Review of Systems

(Please Circle Yes/No)

Constitutional:

Abnormal weight gain:	Yes	No
Night sweats:	Yes	No
Decreased appetite:	Yes	No
Fatigue:	Yes	No

Eyes:

Sudden vision changes:	Yes	No
Double vision:	Yes	No
Visual disturbances:	Yes	No

Ear/Nose/Throat:

Hearing loss:	Yes	No
Ringing in ears:	Yes	No
Altered sense of smell:	Yes	No

Chest:

Nipple tenderness:	Yes	No
Breast enlargement:	Yes	No

Respiratory:

Persistent cough:	Yes	No
Wheezing:	Yes	No
Shortness of breath:	Yes	No

Cardiovascular:

Chest pain/pressure:	Yes	No
Palpitations:	Yes	No
Pain in the lower legs:	Yes	No
Fainting spells:	Yes	No
Dizziness:	Yes	No

Genitourinary:

Urinary frequency:	Yes	No
Pain with urination:	Yes	No

Gastrointestinal:

Abdominal pain:	Yes	No
Nausea/vomiting:	Yes	No
Change in bowel habits:	Yes	No
Change in appetite:	Yes	No
Blood in stool:	Yes	No

Neurological:

Frequent headaches:	Yes	No
Arms and/or leg weakness:	Yes	No
Difficulty with speech:	Yes	No
Chronic pain:	Yes	No

Musculoskeletal:

Joint pain:	Yes	No
Muscle pain:	Yes	No
Muscle weakness:	Yes	No

Integumentary:

Suspicious skin lesions:	Yes	No
Recurrent rashes:	Yes	No
Acne:	Yes	No

Psychiatric:

Depressed mood:	Yes	No
Anxiety:	Yes	No
Irritability:	Yes	No
Insomnia:	Yes	No
Low self-confidence:	Yes	No

Endocrine:

Decreased libido:	Yes	No
Hot/Cold intolerance:	Yes	No
Appetite change:	Yes	No
Excessive thirst:	Yes	No

Financial Responsibility

Please sign your name by whichever statement is true:

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Please choose which option below best fits you:

* I do not have insurance and will be paying out of pocket for all services rendered. I understand that I will be paying 100% of all services rendered.

_____

Signature/Date

* I have insurance and give Paradigm Hormones permission to bill said insurance company for all treatment taken. I also understand that I will be responsible to all charges not paid by my insurance company.

_____

Signature/Date

* I have insurance but would prefer Paradigm Hormones not bill to my insurance company. I understand that I will be responsible 100% for all services rendered.

_____

Signature/Date

*I have insurance but understand that only my office visit and labs will be billed out and I will be responsible to the rest of the charges, including 100% of the pellet cost.

_____

Signature/Date

Consent to Have Blood Drawn:

I authorize the medical staff of Paradigm Hormones LLC to obtain a blood sample for the purpose of running any laboratory testing they deem necessary as determined in the professional discretion of the medical staff.

_____

Signature/Date

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Paradigm Hormones.

_____

Signature/Date

Consent to Order Medical/Prescription History

I authorize the medical staff of Paradigm Hormones LLC to obtain my past medical and prescription history. In order to help with my treatment.

_____

Signature/Date

Consent to Contact

I give consent to Paradigm Hormones to contact me to discuss different aspects of my visits. I understand that some of the reasons they may be contacting me is to discuss lab results, appointment reminders, billing etc.

_____

Signature/Date

Personal Information

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

Today's Date: _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (Check all that apply to you or your family)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at or under age 45*
- ☐ Ovarian cancer at any age*
- ☐ Two primary breast cancers in the same person with one diagnosed at or under age 50*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Three relatives on the same side of the family with breast and/or ovarian cancer at any age
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

- ☐ A personal history of colon/rectal cancer or endometrial cancer diagnosed at or under age 50
- ☐ A personal history of two or more Lynch syndrome cancers***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age

☐ A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment: _____

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Permission for Disclose of Protected Health Information

I hereby acknowledge that I received a copy of this medical practice's Note of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I, _____, give my permission for Paradigm Hormones to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointment times, changes in appointments, doctor or nurse reports about me, and any other information that this office has about me.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ _____

Signature of Patient Date

OPPORTUNITY TO OBJECT

I, _____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

_____ _____

Signature of Patient Date