Paradigm Hormones Restorative Clinic - Female New Patient Info

Name: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ City/State/Zip: _____
Phone #: _____ Email: _____
Occupation: _____ Employer: _____
How did you hear about us? _____
Marital Status (Please Circle): **Married** **Separated** **Divorced** **Single** **Widow**
Children: Y/N If yes, how many? _____ Do you desire more children? Y/N

Emergency Contact Info:
Name: _____
Relationship: _____ Phone: _____

Mediation List:

_____ _____ _____
_____ _____ _____

Drug Allergies: Y/N If yes, please list: _____

Are you currently/have you ever used any form of hormone replacement therapy? Y/N
If yes, please circle: 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 per year _____
Night Sweats:	Yes	No	# of times per day _____
Hot Flashes/Hot Flushes:	Yes	No	# of times per 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
Memory Loss:	Frequently	Rarely	Never
Mood Swings:	Frequently	Rarely	Never
Migraines:	Frequently	Rarely	Never
Depression:	Frequently	Rarely	Never
Anxiety:	Frequently	Rarely	Never
Decreased sexual desire:	Frequently	Rarely	Never
Trouble Focusing:	Frequently	Rarely	Never
Foggy Thinking:	Frequently	Rarely	Never
Muscle/Joint pain:	Frequently	Rarely	Never

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GYN History

Date of LMP (last menstrual period): _____
How many days does your period last? _____
Do you have regular monthly periods? YES NO
Has the flow of your periods changed? YES NO -- Flow (circle): Light Moderate Heavy
If you no longer have a period, please choose a reason:

- ☐ Hysterectomy
- ☐ Ablation
- ☐ Menopause
- ☐ IUD
- ☐ Other:_____

Age at first child: _____
Age at first menstrual cycle: _____
Are you currently pregnant, trying to get pregnant or breastfeeding? YES NO
Current Birth Control method:

- ☐ Pills
- ☐ IUD
- ☐ Condoms
- ☐ Diaphragm
- ☐ Implants
- ☐ Depo
- ☐ Partner Vasectomy
- ☐ Tubal Ligation
- ☐ Other: _____

If post-menopausal, what age did you start menopause? _____
Date of last Colonoscopy: _____
Date of last Pap smear: _____
Date of last Mammogram: _____

Abnormal or Post-menopausal bleeding?	YES	NO	If yes, please explain: _____
Abnormal Pap history?	YES	NO	If yes, how was it treated? _____
Abnormal vaginal or cervical history?	YES	NO	If yes, please explain: _____
Are you sexually active?	YES	NO	
Do you have sexual problems or pain with sex?	YES	NO	
Do you have any STDs/STIs?	YES	NO	If yes, please list: _____
Do you perform self breast exams?	YES	NO	
Do you have any breast lumps or discharge?	YES	NO	
Do you have a uterus?	YES	NO	

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Medical History

Please mark any of the following that you have experienced or are currently experiencing:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Blood Diseases
- ☐ Blood Transfusions
- ☐ Bone Problems
- ☐ Breast Cancer
- ☐ Cardiomyopathy
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Hair Loss
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Iron
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Joint Problems
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Muscle Problems
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Seizers/Epilepsy
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Varicosities
- ☐ Water Retention
- ☐ Other: _____

Surgical History

- ☐ Appendectomy
- ☐ Colonoscopy
- ☐ Gall Bladder Removal
- ☐ Knee Surgery
- ☐ Rhinoplasty
- ☐ Tonsillectomy
- ☐ Hysterectomy
- ☐ Breast Augmentation
- ☐ Caesarian Delivery
- ☐ Wisdom Teeth Removal
- ☐ Other: _____

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Social History – (Please circle Yes/No)

Smoker: Y/N — If yes, how many per day? ____ How many years? _____
Do you chew/dip tobacco? Y/N — If yes, how many times per day? ____
Do you use recreational drugs? Y/N — If yes, please explain: _____
Do you drink alcohol? Y/N — If yes, how many drinks per week? _____
Do you exercise? Y/N
Do you consume caffeine? Y/N

Family History			**LIST THE FAMILY MEMBER & AGE DIAGNOSED BELOW**
Breast Cancer:	YES	NO	_____
Ovarian Cancer:	YES	NO	_____
Colon Cancer:	YES	NO	_____
Lung Cancer:	YES	NO	_____
Skin Cancer:	YES	NO	_____
Kidney Disease:	YES	NO	_____
Diabetes:	YES	NO	_____

Preferred Pharmacy

Location Name: _____
Address: _____
Phone #: _____

Primary Care Physician

Facility/Location: _____
Physician Name: _____ Phone: _____
Address: _____ Fax: _____

NOTICE OF PRIVACY PRACTICES

Paradigm Hormones has privacy practices in place. The notice describes how medical information about you may be used and disclosed, and how you can get access to this information. By signing this, you acknowledge receipt of Paradigm Hormones Notice of Privacy Practices.

Signature: _____ Date: _____

Review of Systems
Please Circle Yes/No:

CONSTITUTIONAL		
Fever	YES	NO
Night Sweats	YES	NO
Weight Gain	YES	NO
Weight Loss	YES	NO
Exercise Intolerance	YES	NO

EYES		
Dry Eyes	YES	NO
Irritation	YES	NO
Vision Change	YES	NO

EAR/NOSE/THROAT		
Difficulty Hearing	YES	NO
Ear Pain	YES	NO
Frequent Nose Bleeds	YES	NO
Nose Problems	YES	NO
Sinus Problems	YES	NO
Sore Throat	YES	NO
Bleeding Gums	YES	NO
Snoring	YES	NO
Dry Mouth	YES	NO
Oral Abnormalities	YES	NO
Mouth Ulcer	YES	NO
Teeth Abnormalities	YES	NO

CARDIOVASCULAR		
Chest Pain	YES	NO
Arm Pain	YES	NO
Shortness of Breath	YES	NO
Palpitations	YES	NO
Heart Murmur	YES	NO
Light-headed	YES	NO

RESPIRATORY		
Cough	YES	NO
Wheezing	YES	NO
Shortness of Breath	YES	NO
Coughing up Blood	YES	NO
Sleep Apnea	YES	NO

GASTROINTESTINAL		
Abdominal Pain	YES	NO
Vomiting	YES	NO
Change in Appetite	YES	NO
Black/Tarry Stools	YES	NO
Frequent Diarrhea	YES	NO
Vomiting Blood	YES	NO
Dyspepsia	YES	NO
GERD	YES	NO

GENITOURINARY		
Urinary Loss of Control	YES	NO
Difficulty Urinating	YES	NO
Increased Urinary Frequency	YES	NO
Hematuria	YES	NO
Incomplete Emptying	YES	NO

MUSCULOSKELETAL		
Muscle Aches	YES	NO
Muscle Weakness	YES	NO
Joint Pain	YES	NO
Back Pain	YES	NO
Swelling in Extremities	YES	NO

INTEGUMENTARY		
Abnormal Mole	YES	NO
Jaundice	YES	NO
Rash	YES	NO
Itching	YES	NO
Dry Skin	YES	NO
Growths/Lesions	YES	NO
Laceration	YES	NO

NEUROLOGIC		
Loss of Consciousness	YES	NO
Weakness	YES	NO
Numbness	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Frequent/Severe Headaches	YES	NO
Migraines	YES	NO
Restless Legs	YES	NO
Tremor	YES	NO

PSYCHIATRIC		
Depression	YES	NO
Sleep Disturbances	YES	NO
Restless Sleep	YES	NO
Alcohol Abuse	YES	NO
Anxiety	YES	NO
Hallucinations	YES	NO
Suicidal Thoughts	YES	NO

ENDOCRINE		
Fatigue	YES	NO
Increased Thirst	YES	NO
Hair Loss	YES	NO
Increased Hair Growth	YES	NO
Cold Intolerance	YES	NO

HEMATOLOGIC/LYMPHATIC		
Swollen Glands	YES	NO
Easy Bruising	YES	NO
Excessive Bleeding	YES	NO

ALLERIC/IMMUNOLOGIC		
Runny Nose	YES	NO
Sinus Pressure	YES	NO
Itching	YES	NO
Hives	YES	NO
Frequent Sneezing	YES	NO

Paradigm Hormones

Account #: _____

Financial Agreement:

Payment Policy: Payment is expected at the time services are rendered. We accept cash, check, VISA, or MasterCard. Arrangements must be made for the payment of any balance greater than $200.

Medicare Patients: We accept Medicare assignment, therefore, we will gladly file your Medicare and secondary insurance claims. However, you will be responsible for your deductible, coinsurance, and any charges not covered by Medicare.

Returned Checks and Non-Payment of Account: All returned check will be subject to a collection fee. Returned checks not paid within 30 days of receipt will be turned over to the District Attorney's office. Receipt of two (2) returned checks in any 12-month period will result in our inability to accept future payments by check from you. Payments at that time will need to be in cash, money order, or credit card.

Accounts that are delinquent for greater than 90 days will be turned over to our collection department for handling. Once your account has been turned to the collection department, it must be paid in full before another appointment can be scheduled.

Insurance: Please remember, your insurance is a contract between you and the insurance company. As a service to you, we will be happy to file your insurance. However, the ultimate responsibility for all charges is yours. It is also your responsibility to make sure your insurance is active and current the day you are seen in the office.

Completion of Insurance/Employer Forms: There will be a completion fee for each form requested to be filled out for your insurance company or employer. Payment must accompany forms at the time of the request. Please allow at least 3 business days for completion of such forms.

_____ **INITIAL**

Prescription Policy:

Paradigm Hormones diagnoses and treats hormonal conditions. On occasion, we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patient, unborn fetuses and others. For this reason, the State of Oklahoma and the Federal Drug Enforcement Administration regulate the use of medications. Paradigm Hormones follows those laws.

Our policy:

1. Written prescriptions will NOT be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. DO NOT change the frequency of the dose unless otherwise directed by a Paradigm Hormones professional. If a change does occur this will be documented in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions cannot be refilled.
    a. Sleep aids such as: Ambien, Lunesta
    b. Anti-inflammatories such as: Celebrex, Bextra
    c. Narcotics such as: Lortab, Vicodin, Hydrocodone
    d. Muscle Relaxers such as: Soma, Flexeril, Robaxin
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Paradigm Hormones, please check your supply of medication. If you need a refill, please ask during your appointment.
8. Refills requests for hormone replacement medications and birth control pills can only be refilled if you have a routine gynecology appointment scheduled.
9. Refill requests for prescriptions not prescribed by Paradigm Hormones will not be authorized.
10. Prescription requests made prior to 12 noon will be available at your pharmacy after 5pm that day. Requests made after 12 noon will be available at your pharmacy after 10am the following morning.

Signature: _____ **Date:** _____

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Request for Release of Protected Health Information (HIPPA)

This form will be used to release your protected health information as required by federal and state privacy laws. Your authorization allows Paradigm Hormones to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Paradigm Hormones. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Your Information:

Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Phone: _____

SSN: _____

I authorize my physicians, medical professionals, Paradigm Hormones, and its agents/affiliates to release my protected health information as described below:

Recipient: _____

Relationship: _____ Phone: _____

Address: _____

Manner of Release:

- ☐ Records shall be made available for Pick-up only
- ☐ Records shall be mailed to recipient to: _____
- ☐ Records shall be faxed to recipient to: _____
- ☐ Records shall be emailed to recipient to: _____
- ☐ Any of the above

Description of Information to be Released:

- ☐ Lab Results
- ☐ All Medical Records
- ☐ Specific information as described: _____

Purpose of Release:

_____

This authorization will expire (please check one of the following):

- ☐ When I revoke this authorization
- ☐ On this date, event or condition: _____

"I affirm all the information supplied is true and correct. I further understand that this authorization to release information is voluntary and is not a condition of treatment, eligibility for benefits, or payment or claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. I request that Paradigm Hormones release the protected health information described above to the persons and/or entities listed above for the purposes set forth above."

_____ _____

Signature **Date**