

# ***FEMALE CONFIDENTIAL EVALUATION AND HEALTH HISTORY***

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies and/or metabolic imbalances. The answers provided in the questions below will allow the practitioner to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

**Please bring in or mail copies of the following labs you may have had within the last year:**

- 1. Complete Blood Count**
- 2. Chem Screen (cholesterol, blood sugar, liver enzymes, electrolytes, etc.)**

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### **GENERAL INFORMATION:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_

Occupation: \_\_\_\_\_  Full-Time  Part-Time  Retired  Unemployed  Other

Living Situation:  Spouse  Alone  Partner  Friend(s)  Parents  Children  Other

Status:  Married  Single  Divorced  Widowed

How did you hear about Natural Hormone Replacement Therapy (HRT):  Ad  Another Patient  Friend

Physician/Healthcare practitioner  Books/Articles  Class/Seminar  Other

If you had a referral, who referred you? \_\_\_\_\_

Have you discussed HRT with your Health Care Practitioner? \_\_\_\_\_

Do you understand what Natural Hormone Replacement is? \_\_\_\_\_

What are your three main symptoms/concerns? 1. \_\_\_\_\_ Since When? \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What is the age you are? \_\_\_\_\_ What is the age you feel? \_\_\_\_\_

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### **MEDICAL STATUS:**

**Primary Health Care Practitioner/Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Other Physicians Currently Seeing: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

General Health:  Excellent  Good  Fair  Poor Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Drug allergies/reaction to vaccines: \_\_\_\_\_

Current Diagnosis or Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Vitamins or OTC products: **(Please list ALL products, including daily dosage.)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Herbs/etc.: \_\_\_\_\_

\_\_\_\_\_

Are you currently on Natural Progesterone cream?  Y  N If yes, brand name: \_\_\_\_\_

How long have you been on Progesterone cream: \_\_\_\_\_ How much are you using and when: \_\_\_\_\_

Current Hormone Replacement Therapy: Name \_\_\_\_\_

Strength \_\_\_\_\_ Date started: \_\_\_\_\_

How and when do you take current HRT? \_\_\_\_\_

Previous Hormone Replacement Therapy: Name \_\_\_\_\_

Strength: \_\_\_\_\_ Reason For Change: \_\_\_\_\_

\_\_\_\_\_

Bone Density:  Y  N Date: \_\_\_\_\_ Type:  Back  Hip T-Score: \_\_\_\_\_

Have you ever had a mammogram:  Y  N Date: \_\_\_\_\_ Results: \_\_\_\_\_

**Have you ever had your Thyroid tested:**  Y  N **Date:** \_\_\_\_\_

**TSH** \_\_\_\_\_ **Free T4** \_\_\_\_\_ **Free T3** \_\_\_\_\_ **Other** \_\_\_\_\_

**CURRENT AND PAST MEDICAL CONDITIONS:**

Please check the ones that apply to you

	Y	N	Date of Diagnosis		Y	N	Date of Diagnosis
Asthma				High Blood Pressure			
Arthritis				Irritable Bowel			
Autoimmune Disorder				Kidney Trouble			
Cancer				Liver Disease			
Chronic Fatigue				Osteoporosis			
Clotting Defects				Other (explain)			
Colitis							
Depression/Anxiety							
Dental Issues							
Diabetes				Stroke			
Eating Disorder				Surgeries (explain)			
Epilepsy							
Fractures							
Fibrocystic Breasts							
Fibromyalgia							
Gallbladder trouble				Ulcer			
Heart Disease				Varicose Veins			

**HABITS:**

Dietary Restrictions/Food Cravings/Intolerances: \_\_\_\_\_

Average Meal Choices:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Do you regularly skip meals:  Y  N \_\_\_\_\_

Do you get routine exercise:  Y  N What type: \_\_\_\_\_ How often: \_\_\_\_\_

Do you use tobacco products:  Y  N How Much: \_\_\_\_\_ How Long: \_\_\_\_\_

Do you use alcohol products:  Y  N How Much: \_\_\_\_\_ How Long: \_\_\_\_\_

Do you use caffeine products:  Y  N How Much: \_\_\_\_\_ How Long: \_\_\_\_\_

Daily Water Intake: \_\_\_\_\_ Drink/bathe in well water?  Y  N

Is there a history of trauma/abuse?: \_\_\_\_\_

Do you have a history of substance abuse?:  Y  N \_\_\_\_\_

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**FAMILY HISTORY:**

	IMPORTANT DISEASES	LIVING	DECEASED
Sons			
Daughters			
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandma			
Paternal Grandpa			
Maternal Grandma			
Maternal Grandpa			

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**GYNECOLOGICAL HISTORY:**

Age at first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Date of last pelvic exam: \_\_\_\_\_ and Pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had an abnormal pap?  Y  N When? \_\_\_\_\_ How many times? \_\_\_\_\_

Treatment: \_\_\_\_\_

Are you sexually active?  Y  N Are you trying to get pregnant?  Y  N

Have you ever been on birth control?  Y  N Brand: \_\_\_\_\_ How long on? \_\_\_\_\_

Side Effects? \_\_\_\_\_

Current birth control method: \_\_\_\_\_ How Long: \_\_\_\_\_

Problem(s) with it?: \_\_\_\_\_ How Long: \_\_\_\_\_

Have you had a tubal ligation?  Y  N When? \_\_\_\_\_ Cycle or symptoms change after? \_\_\_\_\_

Have you had a hysterectomy?  Y  N Partial  Total  When? \_\_\_\_\_

Why? \_\_\_\_\_

Symptoms change after hysterectomy? \_\_\_\_\_

**PLEASE FILL OUT THIS SECTION EVEN IF NOT CYCLING NOW**

How many days from start of one period to the start of next: \_\_\_\_\_

Number of days of flow: \_\_\_\_\_ Amount of bleeding: \_\_\_\_\_

Amount of cramping: \_\_\_\_\_

Premenstrual symptoms: \_\_\_\_\_

Starting and ending when? \_\_\_\_\_

Any current changes in your normal cycle: \_\_\_\_\_

Any bleeding between periods: \_\_\_\_\_ When: \_\_\_\_\_

Any pelvic pain, pressure or fullness? \_\_\_\_\_ Describe: \_\_\_\_\_

Any unusual vaginal discharge or itching? \_\_\_\_\_ Describe: \_\_\_\_\_

Treatment: \_\_\_\_\_

Age at first pregnancy: \_\_\_\_\_ How many full term pregnancies? \_\_\_\_\_

Problems: \_\_\_\_\_

\_\_\_\_\_

Any interrupted pregnancies? Miscarriages  Y  N Abortions  Y  N

Which pregnancy? \_\_\_\_\_ How far along? \_\_\_\_\_

\_\_\_\_\_

Age mother in menopause? \_\_\_\_\_



# SYMPTOMS TO DETERMINE WHICH HORMONES TO TEST FOR FEMALES

## SIGNS / SYMPTOMS FOR FEMALES

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test your Estradiol and Progesterone.

Estrogen/Progesterone Deficiency	Estrogen Excess/Progesterone Deficiency
<input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Memory lapses <input type="checkbox"/> Incontinence	<input type="checkbox"/> Tearful <input type="checkbox"/> Depressed <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Heart Palpitation <input type="checkbox"/> Bone loss <input type="checkbox"/> Headaches
<input type="checkbox"/> Mood Swings <input type="checkbox"/> Tender breasts <input type="checkbox"/> Water retention <input type="checkbox"/> Nervous <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Weight gain – hips <input type="checkbox"/> Bleeding changes	<input type="checkbox"/> Headaches <input type="checkbox"/> Cold body temperature <input type="checkbox"/> Cystic ovaries <input type="checkbox"/> Heavy menses <input type="checkbox"/> Breast cancer <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Sugar craving <input type="checkbox"/> Elevated triglycerides <input type="checkbox"/> Weight gain - waist <input type="checkbox"/> Low libido

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test you Testosterone and DHEA-S.

Androgen Deficiency	Androgen Excess
<input type="checkbox"/> Low libido <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Fatigue <input type="checkbox"/> Aches/pains <input type="checkbox"/> Memory lapses <input type="checkbox"/> Foggy thinking <input type="checkbox"/> Incontinence <input type="checkbox"/> Depressed <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Bone loss	<input type="checkbox"/> Decreased muscle mass <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Headaches <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Irritable <input type="checkbox"/> Thinning skin
<input type="checkbox"/> Increased facial hair <input type="checkbox"/> Increased body hair <input type="checkbox"/> Loss of scalp hair <input type="checkbox"/> Acne <input type="checkbox"/> Oily skin <input type="checkbox"/> Nervous <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Ovarian cycts <input type="checkbox"/> Elevated triglycerides <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Breast cancer	

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test your Cortisol.

Cortisol Deficiency	Cortisol Excess	
<input type="checkbox"/> Fatigue <input type="checkbox"/> Sugar craving <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical sensitivity <input type="checkbox"/> Stress <input type="checkbox"/> Cold body temperature <input type="checkbox"/> Irritable <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Aches/pains	<input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Bone loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain - waist <input type="checkbox"/> Loss of muscle mass <input type="checkbox"/> Thinning skin <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Breast cancer <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Memory lapses <input type="checkbox"/> Depressed	<input type="checkbox"/> Heart palpitations <input type="checkbox"/> Headaches <input type="checkbox"/> Stress <input type="checkbox"/> Cold body temperature <input type="checkbox"/> Sugar cravings <input type="checkbox"/> Low libido <input type="checkbox"/> Hair loss <input type="checkbox"/> Increased facial hair <input type="checkbox"/> Increased body hair <input type="checkbox"/> Acne <input type="checkbox"/> Nervous

## SIGNS / SYMPTOMS FOR FEMALES

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication that testing **IGF-1** for imbalances of human growth hormone (HGH) is recommended.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Sleep disturbances    | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Poor or declining    | <input type="checkbox"/> Thickened heel pads   |
| <input type="checkbox"/> Memory lapses         | <input type="checkbox"/> Premature aging       | <input type="checkbox"/> "quality of life"    | <input type="checkbox"/> Changes in skull/face |
| <input type="checkbox"/> Decreased muscle mass | <input type="checkbox"/> Weight gain-waist     | <input type="checkbox"/> Slowing cognition    | <input type="checkbox"/> Enlarged/thickened    |
| <input type="checkbox"/> Decreased stamina     | <input type="checkbox"/> Bone loss             | <input type="checkbox"/> Decreased exercise   | <input type="checkbox"/> Heart                 |
| <input type="checkbox"/> Decreased libido      | <input type="checkbox"/> Thinning/sagging skin | <input type="checkbox"/> capacity             | <input type="checkbox"/> Chronic neurological  |
| <input type="checkbox"/> Sexual dysfunction    | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Visual field defects | <input type="checkbox"/> conditions            |
|  | <input type="checkbox"/> Insulin resistance    | <input type="checkbox"/> Thickened palms      |  |

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication of the need to test for Thyroid Dysfunction by testing **ft4, ft3, TSH, and/or TPO OR Complete Thyroid Profile.**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Low blood pressure        | <input type="checkbox"/> Decreased muscle mass | <input type="checkbox"/> Bulging eyes         |
| <input type="checkbox"/> Depressed             | <input type="checkbox"/> Slow pulse rate           | <input type="checkbox"/> Thinning skin         | <input type="checkbox"/> Erratic behavior     |
| <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Decreased sweating        | <input type="checkbox"/> Infertility problems  | <input type="checkbox"/> Anxious              |
| <input type="checkbox"/> Cold hands and feet   | <input type="checkbox"/> Hair loss                 | <input type="checkbox"/> Slowed reflexes       | <input type="checkbox"/> Irritable            |
| <input type="checkbox"/> Weight gain           | <input type="checkbox"/> Hair dry or brittle       | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Nervous              |
| <input type="checkbox"/> Can't lose weight     | <input type="checkbox"/> Nails breaking or brittle | <input type="checkbox"/> Thick tongue          | <input type="checkbox"/> Panic attacks        |
| <input type="checkbox"/> Memory lapses         | <input type="checkbox"/> Aches/pains               | <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Decreased mental     |
| <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Decreased libido          | <input type="checkbox"/> Rapid weight loss     | <input type="checkbox"/> sharpness            |
| <input type="checkbox"/> Mood changes          | <input type="checkbox"/> Bone loss                 | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Swelling/puffy eyes   | <input type="checkbox"/> Heart palpitations        | <input type="checkbox"/> Unusual sweating      | <input type="checkbox"/> Rapid heartbeat      |
| <input type="checkbox"/> and/or face           |  | <input type="checkbox"/> Always feeling hot    | <input type="checkbox"/> Goiter               |
| <input type="checkbox"/> Sleep disturbances    |  |  | <input type="checkbox"/> Tremors in fingers   |

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication that testing **Fasting Insulin** is recommended for indications of Insulin Resistance, Metabolic Syndrome and Pre-diabetes.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Food/sugar cravings | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Weight gain – waist | <input type="checkbox"/> Increased urinary urge | <input type="checkbox"/> Low blood sugar        | <input type="checkbox"/> Numbness (hands and |
| <input type="checkbox"/> Difficulty sleeping |   | <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> feet)               |

# Prevention & Healing of Iowa, LLC

\_\_\_\_ Initials

## Informed Consent

I, \_\_\_\_\_, have sought medical care at Prevention & Healing of Iowa (PHI). I do this of my own free will, because I believe that the functional, holistic approach to medicine that is practiced at PHI is more in keeping with my own philosophy of health and well-being.

The nurse practitioner (NP) at PHI is board-certified, licensed in the State of Iowa, and will employ standard, orthodox drug therapy for medical management as well as refer you to physician specialists when indicated.

\_\_\_\_ Initials

## Child Care

We ask that another adult come with parent(s) of children seen in our clinic. This allows us to provide optimal treatment and communication with the parent(s). There may be follow-up consults where it is not necessary to have the child/client along.

\_\_\_\_ Initials

## Office Policies and Procedures for Nurse Practitioner

1. We must have this **signed/initialed** "Office Policies and Procedures for Nurse Practitioner" form returned with your completed Health History form in order to schedule the initial visit.
2. You will receive a courtesy reminder phone call in advance of your appointment(s).

\_\_\_\_ Initials

## Cancellation Policy

**A cancellation on the day of your appointment is inconvenient to other patients waiting for an appointment and costly to PHI.** If you need to cancel or reschedule, kindly do so **24 hours in advance** or you will be charged for that appointment.

There must be a VISA, Master Card, or Discover number on file. **If you do not use a credit/debit card, you will need to send a check for the initial consult fee along with this signed policy prior to reserving your first appointment.**

Name as it appears on credit card (print): \_\_\_\_\_

Credit Card #: \_\_\_\_\_

Type of credit card: VISA / Master Card / Discover/Debit

Date of Expiration: \_\_\_\_\_ Card Verification Code (CVC2 Code) \_\_\_\_\_

I agree to allow Prevention & Healing of Iowa to debit the above credit/debit card account the amount of the initial consult fee in the event I do not show up for my **prescheduled initial appointment and neglect to give 24 hours advance notice.** In addition, I agree to allow Prevention & Healing of Iowa to debit the above credit card account \$150.00 in the event I do not show up for my prescheduled follow-up appointment(s) **without giving 24 hour advance notice.**

**Initials                      Telephone Consults/Questions to the Practitioner**

1. Since the practitioner is not in the office every day, it is possible you may not have a return call or voice mail response that same day.
2. Due to the volume of phone calls and each individual's differing degree of severity of health care needs, a reserved telephone appointment with the practitioner may be necessary at the rate below.
  - a. These telephone/email fees will be explained to you in advance of the phone consult and billed to your credit card account at the time of phone consult.

**Initials                      Fee Structure**

<b>Initial Consult with Carolyn Walker</b>	90 minutes	<b>\$350 to hold appointment time due day of initial consult</b>
<b>Follow Up Visit with Carolyn Walker</b> (may be a phone consult if distance/weather a factor)	Usually 90 minutes or longer depending on lab results/questions	<b>\$200 / hour or \$100 / 30 minutes due day of consult/service</b>
<b>Phone Consult / Email Time</b>	\$3.00 / minute	Depends on # of minutes
<b>Correspondence / Letters to Insurance</b>	\$25 per each 15 minutes	Depends on # of minutes
<b>Copying</b>	\$0.25 per sheet	Depends on # of copies

1. **On average, 90 minute appointments are reserved for a new patient's initial two visits** with the NP. Depending on one's need, often NP visits necessitate one hour or more.

**Initials                      Insurance Payment/Reimbursement of Services**

Although Prevention & Healing of Iowa's NP does not contract with health insurance carriers or submit claims, we do provide the following to assist you in filing for reimbursement with your particular carrier:

1. A statement itemizing payment of services.
2. A medical claim form delineating services provided, by whom, with diagnostic and procedure codes.
3. A cover letter directing your insurance provider to direct reimbursement to you, not PHI.
4. Should your insurance ultimately deny reimbursing your for our services, one can always submit these to their Medical Savings account at a general pretax savings of about 70¢ on each dollar spent.

**I agree with the above informed consent, child care, cancellation / scheduling / fee structure / telephone / payment / reimbursement of services / email / copying policy.**

**Please Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b><u>OFFICE USE ONLY:</u></b>		<input type="checkbox"/> HIPPA <input type="checkbox"/> Demographic Form <input type="checkbox"/> Health HistoryForm
Date Received:		
Appt. Date:	Time:	