

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. 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.)**

GENERAL INFORMATION:

Date: _____

Name: _____ Age: _____ Birth Date: _____

Address (include city/state/zip): _____ Apt. _____

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? _____

MEDICAL STATUS:

Primary Health Care Practitioner/Physician: _____ Phone: _____

Other Physicians Currently Seeing: _____

Dentist: _____ Phone: _____

General Health: Excellent Good Fair Poor Height: _____ Weight: _____ Blood Type: _____

Allergies: _____

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/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: _____

Do you have a history of substance abuse: Y N _____

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

Food Cravings: _____

FAMILY HISTORY:

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

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, L.L.C.
Office Policies and Procedures for Nurse Practitioners, Nurses

_____ **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 practitioners (NPs) at PHI are 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). The child's needs can be tended to by the other adult who may choose to take the child home as initial visits can be lengthy. There will be follow-up visits where it is not necessary to have the child/client along.

_____ **Initials**

Cancellation / Scheduling / Fee Structure / Telephone Policy

1. We must have this **signed/initialed** "Office Policies and Procedures for Nurse Practitioners, Nurses" form returned with your completed Health History form in order to schedule the initial visit.
2. **On average, 90 minute appointments are reserved for a new patient's initial two visits** with the nurse practitioners (NPs). See fee structure below. Depending on one's need, often NP visits necessitate one hour or more.
3. A 30 minute consult will be scheduled separately for the **initial nurse nutrition consult**.
4. You will receive a courtesy reminder phone call in advance of your appointment(s).

Therefore, **a cancellation on the day of your appointment is inconvenient to other patients waiting for an appointment and costly to us/the clinic.** 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 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 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 Questions to the Practitioner

1. Since the practitioners are 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 practitioners 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.

Initials

Fee Structure

Initial Consult with Carolyn Walker	60- 90 minutes with NP	\$350 (includes 30 minutes with RN nutrition consultant)
Follow Up Visit with Carolyn Walker (may include phone consults)	30minutes - 1 Hour (usual)	\$100 / 30 minutes, \$200 / hour
Nutrition Nurse (RN) Consultant --accepts checks/cash only	1 st 30 minutes Non-NP Consultation, extended or follow-up consults	No Charge when included in initial NP Consult fees \$50 / 30 minutes, \$100 / hour (minimum 1/2 hour)
Phone Consult / Email Time (CRW)	\$3.00 / minute	Depends on # of minutes
Correspondence / Letters to Insurance	\$25 per each 15 minutes	Depends on # of minutes
Copying	\$1.00 per sheet	Depends on # of copies

Initials

Payment/Reimbursement of Services

Although Prevention & Healing of Iowa's NPs do not contract with health insurance carriers, 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.
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:** _____

<u>OFFICE USE ONLY:</u>		
Date Received:		<input type="checkbox"/> HIPPA
		<input type="checkbox"/> Vital Info. Form
Appt. Date:	Time:	<input type="checkbox"/> Health History Form