Vanguard Medical Center

Hormone Consultation Registration

VANGUARD MEDICAL CENTER
711 S. HWY 27, SUITE E
CLERMONT, FL 34711
PHONE: (352) 243-9355 OR (352) 243-9333
FAX: (352) 243-9334
WEBSITE: VANGUARDMEDICALCENTER.COM
EMAIL: INFO@VANGUARDMEDICALCENTER.COM

Vanguard Medical Center
"Life through Balance"

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

PATIENT INFORMATION: NAME INCLUDING SPELLING MUST MATCH INSURANCE			DATE: / /
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	SSN: - -
Preferred Language: ☐ English ☐ Spanish ☐ Other		Driver's License: - -	

Marital Status:	Preferred Contact:	Ethnicity:	Race:
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Mandatory - May We Leave Confidential Information at This Number: ☐ Yes ☐ No ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (Patient Ally)	☐Cambodian ☐Filipino ☐Hispanic/Latino ☐Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian Black or African American ☐ Native Hawaiian/Other Pacific ☐ Islander ☐ White Other

Primary Care Provider:	Referring Provider:

RESPONSIBLE PARTY (GUARANTOR)			☐ SAME AS PATIENT
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	SSN: - -
Preferred Language: ☐ English ☐ Spanish	Driver's License:		

EMERGENCY CONTACT: (FOR MINOR CHILD, THIS SECTION MAY BE USED FOR OTHER PARENT)			
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	
Preferred Language: ☐ English ☐ Spanish			

PRIMARY INSURANCE: PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST. (MANDATORY IF USING INSURANCE)			
Primary Insurance Name:			
Address:	City:	State:	Zip:
Insurance Phone: ( ) -	Work Fax: ( ) -		
Policy or Prescriber/Subscriber ID #:	Group#:	Co-Pay: $ .00	
Relationship to Insured: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER			

SECONDARY INSURANCE::			
Primary Insurance Name:			
Address:	City:	State:	Zip:
Insurance Phone: ( ) -	Work Fax: ( ) -		
Policy or Prescriber/Subscriber ID #:	Group#:	Co-Pay: $ .00	
Relationship to Insured: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER			

EMPLOYMENT:			
Employed by:	Occupation:		
Work Address:	City:	State:	Zip:
Work Phone: ( ) -	Work Fax: ( ) -		

PHARMACY OF CHOICE: MANDATORY			
Address:	City:	State:	Zip:
Phone: ( ) -	Fax: ( ) -		

LABORATORY OF CHOICE: (IF DICTATED BY YOUR INSURANCE PROVIDER**)**

☐ LabCorp ☐ Quest Diagnostics ☐ Vista Clinical Diagnostics ☐ South Lake Hospital ☐ Other:

ADVANCED DIRECTIVES: **DATE REVIEWED: / /**

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Health Care Proxy

HOW DID YOU HEAR ABOUT US:

☐ Postcard ☐ Online Search ☐ Search Engine Name: ☐ Google ☐ Bing ☐ Other_____ ☐ Facebook ☐ Twitter

☐ Family or Friend (Please List)_____ ☐ Other_____

Vanguard Medical Center ● 711 S Hwy 27, STE E ● Clermont, FL 34711 ● 352-243-9355

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

FINANCIAL POLICIES

DIAGNOSTIC TESTING AND OUTSIDE REFERRALS

- **Never assume any test was normal. At Vanguard Medical Center, we aim to serve you in the best way possible. In order to diagnose you, evaluate the effectiveness of a treatment and/or to monitor your health, diagnostic results require a consultation.**
- **We will review lab and imaging results in person, therefore, you will be scheduled for a return appointment 2-3 weeks following your current visit or as your results become available.**
- **Please remember that this is a service that we provide for all our clients to sustain your optimal health. Payment is due at the time services are rendered.**

PRESCRIPTION REFILL POLICY

- **To avoid discrepancies in prescriptions we generally refill prescriptions during office visits. We prescribe enough medication until your next appointment. Before your medication runs low, please call us for an appointment. IT IS YOUR RESPONSIBILITY TO COMPLETE YOUR ORDERED LAB TESTS AND FOLLOW UP WITH AN OFFICE VISIT PRIOR TO RUNNING OUT OF PRESCRIPTIONS.**
- **You should schedule your next visit before you leave our office.**
- **It is very important to request your prescriptions during your office visit.**
- **If you are unable to come to your scheduled visit due to unforeseen circumstances or are overdue for blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in a refill to the pharmacy ONE TIME ONLY, (if deemed medically appropriate) to allow you to re-schedule the missed appointment. If this re-scheduled visit is missed and/ or the required blood work is not obtained, we will be unable to issue any further refills until the above requirements are met. ALL PRESCRIPTION REFILLS require an office visit.**
- **ALL PRESCRIPTIONS REQUIRE A FOLLOW UP APPOINTMENT EVERY 3 TO 6 MONTHS.**
- **We Do Not Refill Medications After Hours.**

FORM COMPLETION

- **Vanguard Medical Center requires payment for the completion of forms the patient asks us to complete on their behalf.**
- **Expected time frame for form completion is 5 – 7 business days from the time of registration; however, we cannot make any assurance of completion with the patient's time frame(s).**
- **Payment is required prior to completion of all forms.**
- **There is a flat rate fee at $25.00 for completion of most forms. Payment is due at the time forms are dropped off at the office. An extra $35.00 is applied for the rush/urgent completion of the forms. We reserve the right to charge additional fees for forms greater than 5 pages. We accept cash, checks or credit cards.**

AFTER HOUR CARE

- **At present we Do Not take care of patients in the hospital. If your condition is such that you require admission to a hospital, please proceed to the nearest hospital or the hospital of your choosing.**
- **We Do Not take call outside of office hours. If you need medical attention when the office is closed, we recommend that you go to one of the local Emergency Room or Urgent Care Center.**

AFFORDABLE CARE ACT MANDATES UPDATES (IMPORTANT PLEASE READ CAREFULLY)

- **Please note that all prescription refills, lab orders, radiology orders (x-ray, mammogram, etc.), and referrals MUST be accompanied by an office visit.**
- **WE CAN NO LONGER WRITE PRESCRIPTIONS OR CREATE ANY ORDERS OVER THE PHONE OR WITHOUT THE PATIENT PHYSICALLY PRESENT. THERE WILL BE NO EXCEPTIONS.**
- **ALL PRESCRIPTIONS REQUIRE A FOLLOW UP APPOINTMENT EVERY 3 TO 6 MONTHS.**
- **These changes are due to the new restrictions within the Affordable Care Act which are designed to reduce insurance and identity fraud in medical procedures, and, as these are Federal laws, cannot be changed or broken by anyone in our office.**
- **To help us, please bring your medications to EVERY appointment, as well as any paperwork you may need your healthcare provider to fill out/sign (See form completion section).**
- **Your annual Lab and Test Orders in your office visits so you do not need to return to get them. PLEASE DO NOT LOSE YOUR ORDERS.**

Vanguard Medical Center
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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

GENERAL CONSENT AND RIGHT TO REFUSE TREATMENT

GENERAL CONSENT TO TREATMENT:

I, _____ (or my authorized representative on my behalf) by signing below, authorize Vanguard Medical Center and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.
I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT:

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.
I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, laboratory tests, and/or minor procedures. I understand that I may discontinue services at any time.

_____ _____-_____-_____
Signature of Patient/Responsible Party **Date**

_____ _____
Name of Patient/Responsible Party (Please Print) **Relationship to Patient**

Vanguard Medical Center ● 711 S Hwy 27, STE E ● Clermont, FL 34711 ● 352-243-9355

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

NOTICE OF PRIVACY PRACTICES

Revised Date: September 23, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU WISH TO REQUEST A DETAILED VERSION OF THIS PRIVACY PRACTICE NOTICE, PLEASE CONTACT THE PRIVACY OFFICER OR VIEW THE FORM ON OUR WEBSITE AT WWW.VANGUARDMEDICALCENTER.COM

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

This facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. The Facility reserves the right to change the Facility's privacy practices and this Notice.

Uses and Disclosures: We may use and disclose your protected health information (PHI) in the following ways:

- ✓ **For purposes of treatment, payment, and hospital operations.**
- ✓ **When release is required by law, including: for military purposes, for law enforcement requests, for national security reasons, or for healthcare regulatory or accrediting agencies.**
- ✓ **In emergency situations or for health and safety reasons.**
- ✓ **To medical examiners, coroners, or funeral directors.**
- ✓ **To organ, tissue, and other donation organizations.**
- ✓ **To contact you about appointment reminders or to tell you about other health-related benefits and services.**
- ✓ **For our directory.**
- ✓ **For Worker's Compensation requests.**
- ✓ **To people who are involved in your care.**
- ✓ **For other purposes as set forth in the full Notice of Privacy Practices.**

All other uses and disclosures by Vanguard Medical Center will require us to obtain from you a written authorization.

Your Rights:

- ✓ **Restrictions: To ask us to limit the information we share, including a right to not have your information disclosed to your health plan when you pay for your services yourself. We will consider requests on an individual basis.**
- ✓ **Confidential communications: To receive your confidential health information by alternate addresses, telephone numbers, or fax numbers.**
- ✓ **Access: To inspect or receive copies of your medical record (Fee required).**
- ✓ **Amendments: To request changes be made to your health information. (The request will be considered on an individual basis.)**
- ✓ **Accounting: To receive a list of our disclosures of your health information.**
- ✓ **This notice: To ask for a copy of our full privacy notice.**
- ✓ **Complaints: If you feel your privacy rights have been violated, please contact the hospital departments listed below to file a complaint with the hospital. You may also complain to U.S. Department of Health & Human Services Office of Civil Rights. You will not be retaliated against for filing a complaint.**

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice. Updates to this notice are effective for all PHI we maintain. We must provide notification to you of a breach of unsecured PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact FRANDZIE DAPHNIS, MSN, FNP-BC, if you wish to file a complaint with the Secretary, please write to: *http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html*

CONTACT INFORMATION

If you have any questions or for clarification on anything contained within this notice, please contact Frandzie Daphnis, MSN, FNP-BC – Vanguard Medical Center Privacy Officer at (352) 243-9355 711 S. Hwy 27, Suite E, Clermont, FL 34711.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices.

_____ _____-_____-_____

Signature of Patient/Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (Please Print) **Relationship to Patient**

Vanguard Medical Center
"Life through Balance"

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

FINANCIAL POLICIES

We are honored that you have entrusted us with your medical needs today and hope that you will recommend us to your friends and use us again in the future should you have need. Finances are always a sensitive subject to address; however, we believe that it is important to address payment issues at the onset of our relationship so that there are no issues for either of us once we begin. Please understand that payment of your bill is considered a part of your treatment. Medical billing has become a complex issue for most Medical Practices. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

WHAT IS THE PAYMENT POLICY?

We request that you pay immediately after you are seen and treated. We do this to keep the cost as low as possible for people who don't have insurance or who have yet to reach their insurance deductible for the year.

HOW MUCH WILL I HAVE TO PAY?

We will be glad to quote you a price before you are seen.

HOW DO I PAY?

- **For your convenience, we accept credit cards including Visa, MasterCard, American Express, Discover, and Debit Cards. WE DO NOT ACCEPT CHECKS.**
- **There will be a $45.00 service charge for all returned checks.**

WHAT IF I DON'T HAVE THE MONEY TODAY?

If you have none of these today, we will be happy to refer you to an alternative medical facility which may be able to work within your financial needs. ANY OUTSTANDING BALANCE WILL NEED TO BE SETTLED BEFORE YOUR NEXT VISIT. ANY UNSATISFACTORY PAYMENT HISTORY WILL REQUIRE PAYMENT PRIOR TO SERVICES RENDERED.

WHAT IF I HAVE INSURANCE?

Co-Pays

- **Co-payment, deductible, or other owed amounts that are the patient's responsibility under the rules of the Medicare or Medicaid program or any other governmental or commercial third-party payor may not be waived. Waiver of co-payments, deductibles, or other owed amounts may be a violation of federal law and is a violation of Vanguard Medical Center's policy.**
- **Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances.**
- **Even if you carry a secondary commercial insurance that may cover your primary insurance co-pay, you are still required to pay your co-pay at the time of service. We do not bill secondary insurance for the primary carrier co-pay.**
- **Failure to pay your entire balance within 30 days, or follow through on payment arrangements will result in your dismissal from the practice.**
- **If you have a high deductible plan, you are responsible for the full cost of your visit until your deductible has been met. (You must pay all the costs up to the deductible amount before your plan begins to pay for covered services you use.)**
- **WE DO NOT BILL INSURANCES THAT WE DO NOT ACCEPT.**

Secondary Insurers

Having more than one insurer DOES NOT necessarily mean that your services will be covered 100%. Secondary insurers will pay based on the response of your primary carrier pays. We DO NOT bill your secondary carrier. You are responsible for any balances after your insurance has cleared the primary bill.

Insurance Coverage Exclusions

There may be certain services (examples: cosmetic procedures, some allergy services, functional medicine tests and services) that are not covered by your health plan. If so, payment is expected at the time of service.

Plan Participation

Although this practice accepts some insurance plans, it is virtually impossible for our office to verify whether or not our providers are covered on your particular plan. So we must ask that you confirm participating provider status directly with your insurance plan before coming in for your appointment. We will not be held responsible for non-coverage of a visit from a plan which we or a certain staff member is not part of the network. You will be expected to pay all balances.

Insurance & Insurance Collection

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments.

However, sometimes involvement from the subscriber (you) is essential in expediting processing and payment of a claim by your insurance plan. We would greatly appreciate your prompt attention to any materials or questionnaires your insurance company may send to you by responding to them immediately, as payment of the claim(s) may be pending your response to such inquiries.

Motor Vehicle Accidents

This office does not bill Auto Insurance for motor vehicle accidents.

Legal Issues

- **Although we may be sympathetic to your cause, we are not a party in any pending litigation you may have filed, and we expect payment in full immediately for services.**

Minor Patients

- **Unaccompanied minors may be denied non-emergency treatment.**

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

TEST COST(S)

Some tests are not offered by routine labs nor covered by insurances. In these cases payment is processed directly by the specialty labs. If ordered, the costs of these tests will be discussed with you at the time they are ordered. Payments Is Due Prior To Testing. If you have insurance, please contact your insurance company for guidance of paid laboratory benefits under your individual plan. We can assume NO liability for cost incurred by ordered test.

MISSED AND CANCELLATION OF APPOINTMENTS

- **In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment.**
- **If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Please do so with a minimum of 24 hours' notice from your appointment time. (i.e Tuesday 9:00 AM appointment should be cancelled no later than Monday 9:00 AM or before).**
- **Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.**
- **Acceptable notification must be received during business hours of operations of Vanguard Medical Center.**
  - **To cancel a Monday appointment, please call our office by 1:00 p.m. on Friday.**
  - **Office Hours: Monday, Tuesday and Thursday 8:30 AM – 4:30 PM, Friday 8:30 AM – 1:00 PM.**
- **FAILURE TO CALL OUR OFFICE DURING BUSINESS HOURS 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TO RESCHEDULE OR CANCEL WILL RESULT IN A CANCELLATION FEE. $100 PER MISSED VISIT**

PAYMENT IS THE SOLE RESPONSIBILITY OF THE PATIENT AND WILL NOT BE BILLED TO YOUR INSURANCE.

1. **Late cancellations**
   - **(A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice) will be considered as a "no-show" and will be subject to the cancellation fee.**
2. **THREE (3) MISSED APPOINTMENTS WITHOUT PRIOR NOTIFICATION, WILL RESULT IN THE IMMEDIATE DISMISSAL FROM OUR PRACTICE.**
3. **If you have not visited the clinic in greater than 1 year, you will no longer be considered an active patient.**
4. **If you are a new patient who does not show up or does not call to cancel your appointment, you will not be allowed to make any further appointments.**

OTHER POLICIES

- **If you have not had a visit with any of our providers after 1 year, your account will become inactive. If you request to re-establish with our practice, you will be considered a new patient and the current policy for new patient acceptance will apply.**
- **We DO NOT allow the re-establishment of a patient once they have transferred care to another primary care physician for any reason other than change of insurance or due to relocation.**
- **If you need printed copies of your medical records for your personal use, we will need a minimum of two-week notice. There will be a charge of $1.00 per page. There will be no charge for medical records if another physician or medical facility is requesting them.**

PLEASE INITIAL EACH BLANK SPACE BELOW:

****IF YOU ARE HELD RESPONSIBLE FOR ABIDING BY THESE POLICY EVEN IF YOU CHOOSE NOT TO SIGN OR INITIAL ****

_____ **I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.**

_____ **I further agree to pay for any missed appointments of which I did not notify the medical office within 24 hours of scheduled time.**

_____ **I authorize to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.**

I have read and understand the financial policies of Vanguard Medical Center, LLC. By my signature I agree to the terms outlined in the financial policies.

_____ **Signature of Patient/Responsible Party**

_____-_____-_____ **Date**

_____ **Name of Patient/Responsible Party (Please Print)**

_____ **Relationship to Patient**

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

PATIENT INFORMATION RELEASE INFORMATION AUTHORIZATION FAMILY AND SIGNIFICANT OTHERS

I understand that by signing this authorization form, at my request, I authorize Vanguard Medical Center and its provider to release specific information to the following individuals:

1. _____ Relationship: _____ Phone: (____) _____
2. _____ Relationship: _____ Phone: (____) _____

I understand that my alcohol and/or drug treatment records are protected under both the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written permission unless otherwise provided for in the regulations. My other treatment records are protected under HIPAA. I also understand that I may cancel this consent in writing at any time except when the release of information has occurred, and that this consent expires automatically as follows:
• the purpose for which it was obtained has occurred, or
• it has been 6 or more days since my discharge from a program of this clinic, whichever is later.
The specific purpose and need for this disclosure is to help arrange for and establish treatment.

☐ **Treatment dates, History, Progress, Recommendations, Admissions, Medications and Discharge Plans**
☐ **Diagnosis and Prognosis which may include acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), human immunodeficiency virus (HIV)**
☐ **Sexually Transmitted Diseases (STDs)**

RE-USE OF INFORMATION:
I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I also understand that under no circumstances am I required to authorize the release of psychotherapy notes.

CONDITIONS:
I understand that I do not have to sign this Authorization form. I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party.

RIGHT TO TAKE BACK AUTHORIZATION:
I understand that I have the right to take back my authorization. If I take back my authorization, I have to notify the Vanguard Medical in writing, I have to sign the notice, and I have to deliver the notice at the following address: Vanguard Medical Center, 711 S. Hwy 27, Suite E, Clermont, FL 34711. The notice will be in effect when received by the Vanguard Medical. Any information already shared by this authorization cannot be taken back.

EXPIRATION:
This authorization will go into effect immediately and will remain in effect until _____ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.
I have read and understand the financial policies of Vanguard Medical Center, LLC. By my signature I agree to the terms outlined in the financial policies.

_____ _____-_____-_____
Signature of Patient/Responsible Party Date

_____ _____
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- It is very important to request your prescriptions during your office visit.
- **IF YOU ARE UNABLE TO COME TO YOUR SCHEDULED VISIT DUE TO UNFORESEEN CIRCUMSTANCES OR ARE OVERDUE FOR BLOOD WORK (NECESSARY FOR MONITORING THE SAFETY OR EFFECTIVENESS OF A MEDICATION), THE PROVIDER MAY AGREE TO CALL IN A REFILL TO THE PHARMACY,** (IF DEEMED MEDICALLY APPROPRIATE) TO ALLOW YOU TO RE-SCHEDULE THE MISSED APPOINTMENT. **IF THIS RE-SCHEDULED VISIT IS MISSED AND/ OR THE REQUIRED BLOOD WORK IS NOT OBTAINED, WE WILL BE UNABLE TO ISSUE ANY FURTHER REFILLS UNTIL THE ABOVE REQUIREMENTS ARE MET. ALL PRESCRIPTION REFILLS** REQUIRE AN OFFICE VISIT.
- **WE DO NOT REFILL MEDICATIONS AFTER HOURS.**

FORM COMPLETION

- Vanguard Medical Center requires payment for the completion of forms the patient asks us to complete on their behalf.
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- **We can NO longer write prescriptions or create any orders over the phone or without the patient physically present**. **THERE WILL BE NO EXCEPTIONS.**
- These changes are due to the new restrictions within the Affordable Care Act which are designed to reduce insurance and identity fraud in medical procedures, and, as these are Federal laws, cannot be changed or broken by anyone in our office.
- To help us, please bring your medications to **EVERY** appointment, as well as any paperwork you may need your healthcare provider to fill out/sign (See form completion section).
- Your annual Lab and Test Orders in your office visits so you do not need to return to get them. **PLEASE DO NOT LOSE YOUR ORDERS.**

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

PATIENT EDUCATION INFORMATION AND HORMONE REPLACEMENT THERAPY INFORMED CONSENT

I, the undersigned, authorize and give my Informed Consent to Vanguard Medical Center for the administration of Bio-Identical hormone replacement therapy.

1. **Expected Benefits of Hormone Replacement Therapy**
   - ✓ Expected benefits include control of symptoms associated with declining hormone levels.
   - ✓ Possible benefits of this therapy may help prevent, reduce or control physical diseases and dysfunction associated with declining hormone levels, through hormonal replacement.
   - ✓ I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.
   - ✓ I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy
2. **Risks and Side Effects of Hormone Replacement Therapy**

   Some of the following risks/adverse reactions are derived from the official Food and Drug Administration "FDA" labeling requirements for these drugs, for therapeutic drug levels in the blood stream. My healthcare provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my blood stream or urine generally associated with those of a 20-35 year-old person and would be within the "normal" or "average" blood concentrations of that age group.

   a. General (**PLEASE INITIAL EACH LINE**)

   _____ I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection.

   _____ I understand that there are risks (both known and unknown) to any medical procedure, treatment and therapy, and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

   _____ I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base an informed consent.

4. **Prescriptions**
   - Hormone therapy prescriptions will be written to provide you with enough refills until your next scheduled office visit. If you are unable to come to your scheduled visit due to unforeseen circumstances or are overdue for blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in a one month refill to the pharmacy, (if deemed medically appropriate) to allow you to re-schedule the missed appointment. **If this re-scheduled visit is missed and/ or the required blood work is not obtained, we will be unable to issue any further refills until the above requirements are met.**
5. **Physical Exams**

   Annual physical exams with prostate/rectal exam (males) or with GYN exam (females) are **required in our office if we are prescribing your hormones even if you have had an exam done with your primary care physician**. This is done for your safety and in compliance with standards set by medical boards.

6. ***Male patients on testosterone***
   - ✓ Testosterone, PSA, Estradiol and CBC levels are monitored every **6 months** (or sooner if medically necessary)
   - ✓ Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover PSA levels once a year. If you have no insurance coverage for this test or if you have a high deductible, we can extend the clinic's discount to you. Please check with our front desk for current prices.
7. ***Female patients on estradiol***
   - ✓ Estradiol, Estrone, Progesterone levels are monitored every **6 months** (or sooner if medically necessary)
   - ✓ Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover them once a year. If you have no insurance coverage for this test or if you have a high deductible, we can extend the clinic's discount to you. Please check with our front desk for current prices.

I do now attest to reading and fully understanding this form, the contents and clinical meanings of such, and discussing these procedures with my healthcare provider and consent to this treatment, and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meanings of its writing and expectations.

If you have any questions as to the risks and benefits of the proposed treatment or any questions concerning the proposed treatment, ask your healthcare provider now before signing this consent form. Please Do Not sign unless you have read and thoroughly understand this form.

Date: _____

Authorized Signature: _____ **Print Name:** _____

Authorized Person's Name: _____ **Relationship to Patient:** _____

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Briefly Describe Your Top 3 Complaints/Symptoms or Reason for Your Appointment: (MANDATORY)

1. _____
2. _____
3. _____

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the provider during your consultation.

This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

What are your health goals for the next year? _____
Where were you getting your care before? _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "**no problems**" if none of the symptoms apply to you.

General
☐ Unexplained weight loss / gain
☐ Unexplained fatigue / weakness
☐ Fall asleep during day when sitting
☐ Fever, chills
☐ **No problems**

Skin
☐ New or change in mole
☐ Rash / itching
☐ **No problems**

Breast
☐ Breast lump / pain / nipple discharge
☐ **No problems**

Ears/Nose/Throat
☐ Nosebleeds, trouble swallowing
☐ Frequent sore throat, hoarseness
☐ Hearing loss / ringing in ears
☐ **No problems**

Eyes
☐ Change in vision / eye pain / redness
☐ **No problems**

Cardiovascular
☐ Chest pain / discomfort
☐ Palpitations (fast or irregular heartbeat)
☐ **No problems**

Respiratory
☐ Cough / wheeze
☐ Loud snoring / altered breathing during sleep
☐ Short of breath with exertion
☐ **No problems**

Gastrointestinal
☐ Heartburn / reflux / indigestion
☐ Blood or change in bowel movement
☐ Constipation
☐ **No problems**

Genitourinary
☐ Leaking urine
☐ Blood in urine
☐ Nighttime urination or increased frequency
☐ Discharge: penis or vagina
☐ Concern with sexual function
☐ **No problems**

Musculoskeletal
☐ Neck pain
☐ Back pain
☐ Muscle / joint pain
☐ **No problems**

Endocrine
☐ Heat or cold sensitivity
☐ **No problems**

Hematologic/Lymphatic
☐ Swollen glands
☐ Easy bruising
☐ **No problems**

Neurological
☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbness / tingling
☐ Unsteady gait
☐ Frequent falls
☐ **No problems**

Allergic/Immune
☐ Hay fever / allergies
☐ Frequent infections
☐ **No problems**

Psychiatric
☐ Anxiety / stress / irritability
☐ Sleep problem
☐ Lack of concentration
☐ **No problems**

Women only
☐ Pre-menstrual symptoms (bloating cramps, irritability)
☐ Problem with menstrual periods
☐ Hot flashes / night sweats
☐ **No problems**

Men only
☐ Erectile Dysfunction
☐ Impotence
☐ Loss of muscle mass, tone, or strength
☐ Problems with urination (decreased stream, frequent night urination)
☐ **No problems**

IMPORTANT: HT_____ft._____in WT____LBS
RECENT ☐ WEIGHT GAIN:_____# TIME FRAME:_____ RECENT ☐ WEIGHT LOSS:_____# TIME FRAME:_____

IMMUNIZATIONS: Check off any vaccinations you have had. **Add year**, if known. Check the box if you don't know the information.
☐ Hepatitis A _____ ☐ Hepatitis B _____ ☐ HPV _____ ☐ Influenza (flu shot) _____ ☐ Meningitis _____
☐ MMR _____ ☐ Pneumovax (pneumonia) _____ ☐ Tetanus (Td) _____
☐ Varicella (Chicken Pox) shot or illness _____ ☐ With Pertussis (Tdap) _____ ☐ Zostavax (shingles) _____

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

ALLERGIES: ☐ **No Known Drug Allergies**

	Allergy	Reaction	Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

MEDICATION: PRESCRIPTIONS. Please list **all** prescriptions birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there. ☐ **Take No Medications**

	Name	Dosage (Milligrams) & How Often Per Day	Reason Prescribed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

MEDICATION: OVER THE COUNTER SUPPLEMENTS/VITAMINS OR MEDICATIONS. Please list **all** non-prescription medications, vitamins, home remedies, herbs, etc. ☐ **Take No Medications**

	Name	Dosage (Milligrams) & How Often Per Day	Reason Taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

HEALTH MAINTENANCE SCREENING TESTS:

Test	*Date*	*Abnormal*	*Comment*
Blood Tests (including blood sugar)		☐ Yes ☐ No	
Lipid (cholesterol)		☐ Yes ☐ No	
Complete Physical Exam		☐ Yes ☐ No	
Sigmoidoscopy or Colonoscopy (circle one)		Polyp ☐ Yes ☐ No	
Bone Density Test		☐ Yes ☐ No	
EKG		☐ Yes ☐ No	
Ultrasound: (Type_____)		☐ Yes ☐ No	
CAT Scan (Type _____)		☐ Yes ☐ No	
Women only:			
Mammogram		☐ Yes ☐ No	
Pap Smear		☐ Yes ☐ No	
Clinical Breast Exam		☐ Yes ☐ No	
Other:			
Men only:			
PSA		☐ Yes ☐ No	
Last Digital Prostate Exam		☐ Yes ☐ No	
Other:			

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

☐ **None**

Condition	*Code*	*Current*	*Past*	*Comments*
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)	**Where?**			
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Condition	*Code*	*Current*	*Past*	*Comments*
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Dental History:		*Current*	*Past*	*Comments*
Amalgams/Silver Fillings				
Bridge(S)				
Crown(S)				
Denture(S)				
Implant(S)				
Jaw Pain				
Periodontal Disease				
Other (list):				
Other (list):				

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal finding or complications.

☐**NONE**

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy		☐Right ☐Left ☐Both		
Breast Surgery		☐Right ☐Left ☐Both		
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal		☐ Laparoscopic		
Heart Surgery (other than coronary bypass)				
Hip Surgery		☐Right ☐Left ☐Both		
Hysterectomy (total, including ovaries)		☐ Laparoscopic ☐Vaginal ☐Abdominal		
Hysterectomy (partial, ovaries left)		☐ Laparoscopic ☐Vaginal ☐Abdominal		
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy		☐Right ☐Left ☐Both		
Breast Surgery		☐Right ☐Left ☐Both		
Colonoscopy				
Coronary Bypass				
Knee Surgery		☐Right ☐Left ☐Both		
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation (“Tubal”)				

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Ovary Removal				
Prostate Surgery				
Sigmoidscopy				
Sinus Surgery				
Surgical Procedure	***Code***	***Yes***	***Year***	***Comments***
Tonsillectomy				
Tonsillectomy & Adenoids				
Vasectomy				
Other (list)				

FEMALE MEDICAL HISTORY: *(For women only)*

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Miscarriage _____
- ❑ Postpartum depression___
- ❑ Caesarean _____
- ❑ Abortion _____
- ❑ Toxemia _____
- ❑ Vaginal deliveries_____
- ❑ Living Children_____
- ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length:_____

Painful: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Date of last menstrual period:____/____/_____

Do you currently use contraception? ☐ Yes ☐ No If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle?

☐ Yes ☐ No

Please advise of any other symptoms that you feel are significant._____

Are you menopausal? ☐ Yes ☐ No If yes, age of menopause_____

Do you currently take hormone replacement? ☐ Yes ☐ No

If yes, what type and for how long?_____

☐ Estrogen ☐ Estradiol ☐ Estrace ☐ Premarin ☐ Progesterone ☐ Provera ☐ Testosterone

☐ Other _____

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

LIFESTYLE:

Tobacco: ☐ Never ☐ Ready to quit ☐ Not ready to quit
☐ Past Smoker Start Date: _____ Quit Date: _____ # Years Smoked: _____
☐ Cigars ☐ Cigarettes ☐ Chewable # PPD: _____
☐ Current Smoker
☐ Cigars ☐ Cigarettes ☐ Chewable
Years Smoked: _____ # PPD: _____ ☐ Intermittent ☐ # Cigarettes _____
☐ Smokeless Tobacco
Years Smoked: _____ # Can/PPD: _____ ☐ Intermittent ☐ # Cigarettes _____

Alcohol: ☐ Never ☐ Ready to quit ☐ Not ready to quit
Frequency: ☐ Rare ☐ Social ☐ Occasionally ☐ Daily ☐ Binge
Quantity: ☐ # Drinks/Day _____ ☐ # Drinks Per Week _____
Type of Alcohol: _____ # Previous Attempt to Quit? _____

Caffeine: ☐ None
☐ Caffeine/Tea/Soda (circle one or more) # Servings per Day: _____
☐ Coffee ☐ Tea ☐ Soda

Recreational Drugs: ☐ Never ☐ Past Quit Date: _____ ☐ Current User
Drug: _____ Have you ever used needles to inject drugs? ☐ Yes ☐ No

Exercise: Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? _____
How long (minutes)? _____ How often? _____

Safety: Do you use a bike helmet? ☐ No bike ☐ Yes ☐ No
Do you use seatbelts consistently? ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No
If you have guns in your home, are they locked up? ☐ Not applicable ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No

Sexual Activity:
Sexually involved currently: ☐ Yes ☐ No Sexual partner(s) is/are/have been: ☐ Male ☐ Female
Birth control method (select all that apply):
☐ None needed ☐Condom ☐Pill ☐Diaphragm ☐Vasectomy ☐Other _____

SOCIAL HISTORY:

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? ☐ Yes ☐ No
Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No
If no, do you believe that stress is presently reducing the quality of your life? ☐ Yes ☐ No
If yes, do you believe that you know the source of your stress? ☐ Yes ☐ No
If yes, what do you believe it to be? _____
Have you ever contemplated suicide? ☐ Yes ☐ No
If yes, how often? _____ When was the last time? _____
Have you ever sought help through counseling? ☐ Yes ☐ No
If yes, what type? (e.g., pastor, psychologist, etc) _____ Did it help? ☐ Yes ☐ No

SLEEP & REST HISTORY

Average number of hours that you sleep at night? ☐Less than 10 ☐ 8-10 ☐ 6-8 ☐ Less than 6
Do you:
☐ Have trouble falling asleep? ☐ Have trouble staying asleep? ☐ Snore?
☐ Feel rested upon wakening? ☐ Yes ☐ No
☐ Use sleeping aids? ☐ Have problems with insomnia?

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

FAMILY HEALTH HISTORY: Please indicate current and past history to the best of your knowledge.

☐**NONE**

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Hormone Analysis for Women

Key: 1=Mild (occurs monthly, 2=Moderate (occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Estrogens Low		Estrogen High (Progesterone High)	
Hot flashes		Mood swings	
Night sweats		Breast tenderness	
Vaginal dryness		Water retention	
Scanty or no menses		Foggy thinking	
Incontinence		Irritability	
Depressed/tearful		Anxiety	
Disturbed sleep		Fibrocystic breasts	
Bone loss		Weight gain especially hips	
Foggy thinking / memory lapse		Heavy periods and/or clots	
Hair loss		Headaches	
Progesterone High		Uterine fibroids	
Increased acne		Fatigue	
Drowsiness		Cold body temperature	
Breast swelling			
Nausea			
Depression			
Foggy thinking			
Oily skin			
Testosterone/DHEA high		**Testosterone/DHEA low**	
Weight gain		Depression	
Insulin resistance		Fatigue	
Loss of scalp hair		Decreased sex drive	
Polycystic ovaries		Decreased muscle mass	
Irritability		Muscle aches/stiffness	
Acne		Bone loss	
Oily skin		Joint aches/pains	
Estrogens Low		**Estrogen High (Progesterone High)**	
Excess facial or body hair		Water retention	
Sore nipples		Reduced sexual performance	

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Hormone Analysis for Men

Key: 1=Mild (occurs monthly, 2=Moderate (occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Date of last PSA: _____ Date of last prostate exam: _____

Thinning of hair on body		Abdominal weight gain	
Thinning of hair on beard		Poor concentration/memory loss	
Reduced libido		Lost of interest in surroundings	
Disturbed sleep		Night sweats	
Depression		Palpitations	
Prostate enlargement/cancer		Insomnia	
Muscle weakness		Thinning skin	
Fatigue		Slow wound healing	
Irritability		Anxiety	
Impotence		Baldness/Balding	

OVERALL HEALTH RATINGS:

Please Use the Following Scale to Describe the Severity: (0= NO symptom, 10= Severe symptom)

Example: _____0 1 2 3 4 (5) 6 7 8 9 10

Energy: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

Sleep: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

Pain: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

Stress: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

GI: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

Libido: 0 1 2 3 4 5 6 7 8 9 10 **(0= NO symptom, 10= Severe symptom)**

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Endocrine Questionnaire

Key: 1=Mild (occurs monthly), 2=Moderate(occurs weekly), 3=Severe (occurs daily), Leave blank if symptom does not occur

Adrenal			
Decreased ability to handle stress		Headache if meals are skipped or delayed	
Feel most energetic after dinner		Irritable or shaky if meals delayed	
Difficulty waking up in the morning		Slow wound healing	
Headache/fatigue after exercising		"Nervous" stomach	
Chronic low back pain, worse with fatigue		Poor blood circulation in heart or arteries	
Become dizzy when stand up suddenly		Inflammation	
Difficulty with manipulative correction		Feeling wired or anxious	
Arthritic tendencies		Type A personality	
Crave salty foods		Wound up yet run down	
Perspire easily		Stressed and fatigued/sleep easily	
Increased efforts to do daily tasks		Stressed and sleep deprived	
Continuing fatigue not relieved by sleep		Exhaustion, insomnia, mild depression	
Lack of energy		Very sensitive to environmental pollutants	
Poor physical stamina, strength, & endurance		Autoimmune conditions	
Decreased mental focus or clarity		Migraines/headaches	
Mental Fatigue		Get sick easily	
Feeling depressed or low for no reason		Irritable or shaky if meals delayed	
Lack of motivation		Weight gain around waist	
Crave sweets or carbs		High Blood pressure	
Fatigue relieved by eating		Insulin resistance	
Loss of scalp hair		Impaired memory	
Low Thyroid			
Difficulty losing weight		Chronic constipation	
Mentally sluggish/reduced initiative		Excessive hair loss or course hair	
Easily fatigued/sleepy during the day		Morning headaches, wear off during day	
Sensitive to cold/poor circulation		Seasonal sadness	
High Thyroid			
Trouble gaining weight even with large appetite		Flush easily	
Nervous, emotional can't work under pressure		Fast pulse at rest	
Inward trembling		Intolerance to heat	

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VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (List below)	❑ Yogurt	
	❑ Slim fast	
	❑ Carnation shake	
	❑ Protein shake	

How much of the following do you consume each week? Please give quantity (cups, # of slices or pieces, ect.)

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

☐ Ovo-lacto ☐ Vegan ☐ Blood type diet ☐ Diabetic

☐ Dairy restricted ☐ Gluten restricted ☐ Vegetarian

☐ _____ ☐ Other (describe) _____

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

Please tell us if there is anything special about your diet that we should know.

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? ☐ Yes ☐ No
If yes, are these symptoms associated with any particular food or supplement? ☐ Yes ☐ No
If yes, please name the food or supplement and symptom(s): _____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more) ☐ Yes ☐ No

Do you feel worse when you eat a lot of?

☐ High fat foods
☐ High protein foods
☐ High carbohydrate foods (breads, pasta, potatoes) ☐ Refined sugar (junk food)
☐ Fried foods
☐ 1 or 2 alcoholic drinks
☐ Other_____

Do you feel better when you eat a lot of?

☐ High fat foods
☐ High protein foods
☐ High carbohydrate foods (breads, pasta, potatoes) ☐ Refined sugar (junk food)
☐ Fried foods
☐ 1 or 2 alcoholic drinks
☐ Other_____

Vanguard Medical Center
"Life through Balance"

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Key: 1=Mild (occurs monthly), 2=Moderate(occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Vitamin Need			
Muscles become easily fatigued		Can hear heart beat on pillow at night	
Feel exhausted or sore after moderate exercise		Whole body or limp jerk as falling asleep	
Vulnerable to insect bites		Night sweats	
Loss of muscle tone, heaviness in arms/legs		Restless leg syndrome	
Enlarged heart or congestive heart failure		Cracks at corner of mouth (Cheilosis)	
Pulse below 65 per minute		Fragile skin, easily chaffed, as in shaving	
Ringing in the ears (tinnitus)		Polyps or warts	
Numbness tingling, or itching in hands/feet		MSG sensitivity	
Depressed		Wake up without remembering dreams	
Fear or impending doom		Small bumps on back of arms	
Worrier, apprehensive anxious		Strong light at night irritates eyes	
Nervous or agitated		Nosebleeds and/or tend to bruise easily	
Feelings of insecurity		Bleeding gums when brushing teeth	
Heart races			
Digestive System			
Bad breath (halitosis)		Food allergies/sensitivities	
Sweat has a strong odor		Sinus congestion, "stuffy head"	
Excessive foul smelling lower bowel gas		Airborne allergies	
Undigested food in stools		Taken antibiotic for total accumulated time of (0=never, 1=<1 month, 2=<3 month, 3=>3 months)	
Sense of excess fullness after means		Fungus or yeast infections	
Bloating within 1 hour or eating		Heartburn or acid reflux	
Are you a vegan?		Feel better if you don't eat	
Loss of taste for meat		Stomach upset by taking vitamins	
Stools hard or difficult to pass		Bloating/gas/belching 1 to 2 hours after eating	
Anus Itches		History of parasites (0=no, 1=yes)	

VANGUARD MEDICAL CENTER – HORMONE CONSULTATION REGISTRATION

PAIN ASSESSMENT QUESTIONNAIRE

Are you currently in pain? ☐ Yes ☐ No
Is the source of your pain due to an injury? ☐ Yes ☐ No
If yes, please describe your injury and the date in which it occurred:
_____
_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to:
_____
_____

Please Use The Area(S) And Illustration Below To Describe The Severity Of Your Pain.
(0= no pain, 10= severe pain)
Example: **Neck** _____
0 1 2 3 4 5 6 7 8 (9) 10

Area 1._____
1 2 3 4 5 6 7 8 9 10

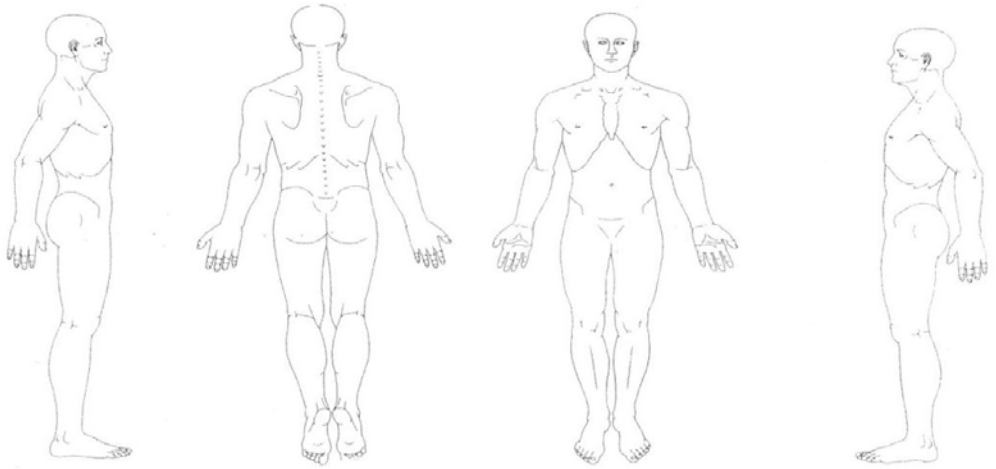
Area 2._____
1 2 3 4 5 6 7 8 9 10

Area 3._____
1 2 3 4 5 6 7 8 9 10

Area 4._____
1 2 3 4 5 6 7 8 9 10

Use The Letters Provided To Mark Your Area(S) Of Pain On The Illustration.

A = Ache **B**= Burning **N**=Numbness **S**= Stiffness **T**=Tingling **Z**=Sharp/Shooting



By My Signature, I Attest That I Have Read and Answered This Questionnaire Truthfully. (MANDATORY)

Date: _____
Patient Signature or Representative: _____ **Print Name:** _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.
Welcome to Vanguard Medical Center and we look forward to helping you achieve lifelong health and well-being.
Sincerely,

Frandzie Daphnis MSN, FNP-BC