Patient Name _____

# Female Patient Questionnaire & History

## PATIENT INFORMATION

Name: _____ Date: _____

Birth Date: _____ Age: _____ Weight:_____lbs Height:_____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Mobile Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

Occupation: _____

Preferred Pharmacy: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Office Phone: _____

Would you like to authorize Sozo Integrative Health to have permission to speak to the individual named below about your treatment? By giving the information below you are giving us permission to speak with the individual about your treatment.

Name: _____ Relationship: _____ Phone: _____

## MEDICATIONS/ MEDICATION ALLERGIES

Drug Allergies: _____

Current Medications & Dose:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

## SOCIAL HISTORY

Sexually Active □ Yes □ No I have completed my family □ Yes □ No

Current Method of Birth Control _____

Current/Past Hormone Replacement Therapy □ Yes □ No If Yes, What? _____

## MEDICAL HISTORY

- ○ High blood pressure
- ○ Heart disease/ Stroke/ High Cholesterol
- ○ Atrial fibrillation or other arrhythmia
- ○ Blood clot and/or a pulmonary embolism
- ○ Depression/Anxiety/ Psychiatric Disorder
- ○ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ○ Hair Loss/ Excessive Hair Growth
- ○ Sleep apnea / Snoring
- ○ Kidney Disease
- ○ Last Colonoscopy _____
- ○ Prostate Issues
- ○ HIV
- ○ Hemochromatosis / Anemia
- ○ Erectile Dysfunction
- ○ Thyroid Disease
- ○ Diabetes / Prediabetes
- ○ Cancer: _____
- ○ Lupus or other autoimmune disease
- ○ Other: _____

Surgical History/ Date:

_____ _____

_____ _____

_____ _____

## FAMILY HISTORY / RELATION

- ○ Heart Disease _____
- ○ Diabetes _____
- ○ Osteoporosis _____
- ○ Alzheimer's/Dementia _____
- ○ Cancer/Type? _____
- ○ Stroke _____
- ○ Lung Disease _____
- ○ Other: _____

## HABITS

I exercise _____ times a week

Type(s) of exercises: _____ Duration (mins): _____

I use E-cigarettes / Vapes: □ No □ Yes, _____ times per day
I smoke cigarettes / cigars: □ No □ Yes, _____ times per day
I use Marijuana: □ No □ Yes, _____ times per day
I drink alcoholic beverages: □ No □ Yes, _____ drinks per day / week
I use caffeine: □ No □ Yes, _____ times / cups per day

## MENSTRUAL HISTORY

Age of Onset: _____ Last Pap smear: _____ Last Mammogram: _____

Irregular/Heavy Periods □ No □ Yes
Cramps □ No □ Yes
PCOS □ No □ Yes
Endometriosis □ No □ Yes
Uterine Fibroids □ No □ Yes
Infertility □ No □ Yes
Menstrual Migraines □ No □ Yes
Breast / Uterine / Ovarian Cancer □ No □ Yes

## FEMALE SYMPTOMS CHECKLIST

**Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box per line.***
**For symptoms that do not apply, please mark NONE**

| | None | Mild | Moderate | Serious | Severe |
|---|---|---|---|---|---|
| **Decline in your feeling of general well-being** (general state of health, subjective feeling) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Hot flashes, excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Heart discomfort** (unusual awareness of heartbeat, heart skipping, heart racing, tightness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Irritability** (feeling aggressive, easily upset about little things, moody) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Nervousness** (inner tension, restlessness, feeling fidgety) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Anxiety** (inner restlessness, feeling panicky) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Physical / Mental exhaustion / lacking vitality** (general decrease in performance, reduced activity, decrease in concentration, forgetfulness, feeling of getting less done, of achieving less, of having to force oneself to undertake activities) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse) | ☐ | ☐ | ☐ | ☐ | ☐ |

Please share any additional symptoms or comments about your symptoms you would like to address:

_____

Do you have cold hands and feet? ☐ Yes ☐ No Do you have daily bowel movements? ☐ Yes ☐ No
Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

**FOR OFFICE USE ONLY**

Patient Name: _____ DOB: _____ Appt Date: _____

Patient Name _____

# HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. These policies have been our standard practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We practice the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Print Name: _____

Signature: _____ Date: _____

# FEE ACKNOWLEDGEMENT

There is no guarantee of reimbursement from insurances for Bio-Identical Hormone Replacement Therapy. You will be responsible for payment in full at the time of your BHRT procedure (see fee schedule below).

- New Female Patient Consultation: **$200**
- Female Hormone Pellet Insertion: **$450 initial / $400 returning**
- 6 Week Post Pellet Follow up: **$75**
- Non-Farmakeio Pharmacy Management: **$20**

Print Name: _____

Signature: _____ Date: _____

**We accept the following forms of payment**

American Express, MasterCard, Visa, Discover, Checks, Cash, FSA/HSA cards

* Insurance receipt provided upon request