ENHANCED WELLNESS *of* NEW MEXICO
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FEMALE HORMONE QUESTIONNAIRE *and* HISTORY

PERSONAL HISTORY

Patient name: .... Date: ....

Date of birth: .... Age: .... Occupation: ....

Home address: ....

City: .... State: .... Zip: ....

Home phone: .... Cell phone: .... Work phone: ....

e-Mail address: .... May we contact you via email? ☐ Yes ☐ No

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EMERGENCY CONTACT INFORMATION:

Name: .... Relationship: ....

Home phone: .... Cell phone: .... Work phone: ....

Primary Care physician's name: .... Phone: ....

Address: ....

City: .... State: .... Zip: ....

MARITAL STATUS (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Cohabitating

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By completing the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's name: .... Relationship: ....

Home phone: .... Cell phone: .... Work phone: ....

SEXUAL:

☐ I am sexually active

☐ I want to be sexually active

☐ I have completed my family

☐ My sexual life has suffered

☐ I haven't been able to have an orgasm

HABITS:

☐ I smoke cigarettes or cigars: .... per day

☐ I drink alcoholic beverages: .... per week

☐ I drink more than 10 alcoholic beverages a week

☐ I use caffeine .... times a day

MEDICAL HISTORY

Any known drug allergies? ....

Have you ever had any issues with anesthesia? ☐ Yes ☐ No

If yes, please explain: ....

Medications currently taking: ....

Current hormone replacement therapy: ....

Past hormone replacement therapy: ....

Nutritional/vitamin Supplements: ....

Surgeries — list all and when: ....

Last menstrual period (estimate year if unknown): ....

Any other pertinent information: ....

....

PREVENTATIVE MEDICAL CARE:

- ☐ Medical/GYN exam in the last year
- ☐ Mammogram in the last 12 months
- ☐ Bone density in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months

HIGH RISK PAST MEDICAL/SURGICAL HISTORY:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy — Removal of ovaries

BIRTH CONTROL METHOD:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Other: ....

MEDICAL ILLNESSES:

- ☐ High blood pressure
- ☐ Heart bypass
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke and/or heart attack
- ☐ Blood clot and/or a pulmonary emboli
- ☐ Arrhythmia
- ☐ Any form of hepatitis or HIV
- ☐ Lupus or other auto-immune disease
- ☐ Fibromyalgia
- ☐ Trouble passing urine
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Cancer (type): .... Year: ....
- ☐ Depression/anxiety
- ☐ Psychiatric disorder ....

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BHRT CHECKLIST *for* WOMEN

Patient name: .... eMail: .... Date: ....

SYMPTOM	NEVER	MILD	MODERATE	SEVERE
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/Severe headaches				
Difficulty sexually climaxing				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair loss				
Cold all the time				
Swelling all over body				
Joint Pain				

Other symptoms that concern you:

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FEMALE TESTOSTERONE *and/or* ESTRADIOL PELLET INSERTION

CONSENT FORM

Patient name: .... Date: ....

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are made from yam and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone cannot be given to pregnant women.

My birth control method is (please check):

☐ Abstinence ☐ Birth control pill ☐ Hysterectomy
☐ IUD ☐ Menopause ☐ Tubal ligation
☐ Other

CONSENT FOR TREATMENT:

☐ **I CONSENT** to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. Surgical risks are the same as for any minor medical procedure.

SIDE EFFECTS MAY INCLUDE: Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood

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swings, anxiety and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

I agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy.

I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name .... Signature .... Date ....

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (aesthetic medicine) and therefore is not covered by health insurance in most cases.

PLEASE NOTE: Enhanced Wellness of NM is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be discarded. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

We accept the following forms of payment:

MasterCard | Visa | Discover | Personal checks | Cash

Print Name .... Signature .... Date ....