Female Initial Health Assessment & Consents

NORTHVIEW MEDICAL

Patient Information

Today's Date: _____

Name:_____ Date of Birth: _____

Current Weight: _____ Height: _____

Home Address: _____ Email Address: _____

Phone Number: _____ Occupation: _____

May we leave detailed messages at this phone number? ☐Yes ☐No

May we send text messages regarding appointments and/or treatment? ☐Yes ☐No

Primary Care Provider: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

In the event that we are unable to contact you by the means provided above, please designate someone that you give us permission to talk to about your treatment. By giving the information below, you consent to us speaking with the designated individual.

Name: _____ Relationship: _____

Phone Number: _____

We are so glad that you are here! Would you mind sharing how you heard about us?

_____

Please briefly describe the main reasons that you are here today:

_____

_____

_____

_____

_____

_____

NORTHVIEW MEDICAL

Female Health Assessment Questionnaire

Please mark the appropriate box for each symptom:

Symptoms	None	Mild	Moderate	Severe	Very Severe
Physical exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life", feeling sad or down)	☐	☐	☐	☐	☐
Joint and/or muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or pain with intercourse	☐	☐	☐	☐	☐
Sexual problems (changes in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss (rapid or thinning)	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands and/or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet and exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased frequency or urgency)	☐	☐	☐	☐	☐

Lifestyle Assessment:

1. **Weight & Lifestyle History**

- How long have you been trying to lose weight? _____
- Previous weight loss methods (diets, medications, programs):

- What worked? _____
- What did not work? _____

Biggest challenges with weight loss:

☐ Hunger
☐ Cravings
☐ Emotional eating
☐ Lack of time
☐ Low energy
☐ Medical issues
☐ Other: _____

---

2. **Current Diet Assessment**

Typical Daily Intake (24-Hour Recall):

Breakfast:

Mid-morning snack:

Lunch:

Afternoon snack:

Dinner:

Evening snack:

Beverages (type & quantity):

Do you have any food allergies or foods you don't like to eat:

---

3. **Additional Questions:**

- How many meals per day do you typically eat? _____
- Do you eat late at night? ☐ Yes ☐ No
- Frequency of eating out: _____ times/week
- Water intake: _____ oz/day

Dietary Patterns:

☐ High protein
☐ High carbohydrate
☐ High fat
☐ Vegetarian/Vegan
☐ Keto/Low-carb
☐ Other: _____

---

4. **Physical Activity**

Current Exercise Routine:

- Type(s) of exercise: _____
- Frequency (days/week): _____
- Duration per session: _____ minutes

Activity Level:

☐ Sedentary (little/no exercise)
☐ Lightly active (1–2 days/week)
☐ Moderately active (3–4 days/week)
☐ Very active (5+ days/week)

Barriers to exercise:

☐ Time
☐ Motivation
☐ Pain/injury
☐ Access to facilities
☐ Other: _____

---

5. **Sleep Habits**

- Average hours of sleep per night: _____
- Bedtime: _____ Wake time: _____

Sleep Quality:

☐ Excellent
☐ Good
☐ Fair
☐ Poor

Do you experience:

☐ Difficulty falling asleep
☐ Frequent awakenings
☐ Snoring
☐ Daytime fatigue
☐ Diagnosed sleep apnea

6. Behavioral & Mental Health

- Do you eat in response to stress/emotions? ☐ Yes ☐ No
- Stress level (1–10): _____
- Mood: ☐ Stable ☐ Anxious ☐ Depressed ☐ Other: _____

Support system:
☐ Strong ☐ Moderate ☐ Limited

---

7. GLP-1 Therapy Considerations

- Have you used GLP-1 medications before? ☐ Yes ☐ No
  If yes, which one(s): _____
- Any history of:
  ☐ Pancreatitis
  ☐ Gallbladder disease
  ☐ Thyroid cancer or MEN2
  ☐ Severe gastrointestinal disease

---

8. Goals & Expectations

- What are your primary goals with treatment?

- What would success look like in 3–6 months?

- Are you willing to:
  ☐ Modify diet
  ☐ Increase activity
  ☐ Track food intake
  ☐ Attend follow-ups

Personal Health History

- Currently pregnant or trying to conceive? ☐Yes ☐No
- Have you had a mammogram within the last year? ☐Yes ☐No
    - Was it normal? ☐Yes ☐No
- Have you had a menstrual cycle within the last 12 months? ☐Yes ☐No
    - If yes, date of last menstrual period:_____
- Have you had an endometrial ablation? ☐Yes ☐No
- Are you currently using any form of birth control (including vasectomy)? ☐Yes ☐No
    - If yes, what kind: _____
- Are you currently utilizing any hormone replacement therapy? ☐Yes ☐No
- Have you had a hysterectomy? ☐Yes ☐No
    - If yes: ☐ Complete (uterus and ovaries removed) ☐ Partial (uterus only removed)
- Are you a smoker? ☐Yes ☐No If yes, how many cigarettes per day? _____
- Are you currently taking oral nitrates (ex. Isosorbide, nitroglycerine, etc.)? ☐Yes ☐No
- Do you currently wear a CPAP or BiPAP machine? ☐Yes ☐No

Personal Medical History:

Please select all the apply:

Cardiovascular Conditions:

☐ Heart Attack or Stroke (within the last 6 months)

☐ Tachycardia

☐ DVT or blood clot (within the last 6 months)

☐ Hypertension

☐ Hyperlipidemia

☐ Obstructive Sleep Apnea

☐ Takes anticoagulant medication

☐ Atrial fibrillation

Cancer:

☐ Breast cancer or History of Breast Cancer

☐ Endometrial Cancer

☐ Cervical Cancer

☐ Ovarian Cancer

☐ Thyroid cancer or History of Thyroid Cancer

☐ Basal Cell Carcinoma

☐ Any other form of cancer?

_____

Medical History continued:

Gynecologic Conditions:

☐ Pre-Menstrual Syndrome

☐ Endometriosis or History of Endometriosis

☐ Fibrocystic Breast Disease

☐ Fibroids or History of Fibroids

☐ Polys or History of Endometrial Polyps

Neurological Conditions:

☐ Epilepsy or Seizure Disorder

☐ Depression/Anxiety

☐ Psychiatric Conditions

☐ Migraine with Aura

☐ Meningioma

Endocrine and Metabolic:

☐ PCOS

☐ Diabetes Type 2 or Insulin Resistance

☐ Hyperthyroid

☐ Hypothyroid

☐ Multiple endocrine neoplasia type 2

Autoimmune Conditions:

☐ Diabetes Type 1

☐ Hashimoto's Thyroiditis

☐ Grave's Disease

☐ Rheumatoid Arthritis

☐ Multiple Sclerosis

☐ Systematic Lupus (Erythematosus)

☐ Psoriasis

☐ IBS (irritable bowel syndrome)

☐ Crohn's Disease

☐ Ulcerative Colitis

Organ Specific Conditions:

☐ Liver Disease or History of Liver Disease

☐ Kidney Disease or History of Kidney Disease

☐ LAM (Lymphangioleiomyomatosis)

☐ Osteoporosis or Osteopenia

☐ HIV

☐ Hepatitis

☐ Hemochromatosis

☐ Pancreatitis or History of Pancreatitis

☐ History of Gall Bladder Disease

☐ Polycythemia Vera (PV)

Medications & Allergies:

- Do you have any medication allergies? ☐Yes ☐No
  - If yes, please list: _____
- Do you have an allergy to latex? ☐Yes ☐No
- Do you have allergies or intolerance to adhesives (ex bandaids etc.)? ☐Yes ☐No
- Please list all medications and/or supplements that you are currently taking with the dose?

_____

_____

_____

Family History:

Family Member	Pancreatitis	Diabetes	Medullary Thyroid Cancer	Multiple Endocrine Neoplasia	Heart Disease	Breast Cancer	Osteoporosis	Alzheimer's/ Dementia	Deceased	Cause of Death
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Symptoms & Concerns:

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Decreased Desire/ Interest in Sex
- ☐ Inability to or Delayed Orgasm
- ☐ Painful Intercourse
- ☐ Urinary Incontinence
- ☐ Breast Tenderness
- ☐ Weight Gain
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Thinning Eyebrows
- ☐ Cold Hands and Feet
- ☐ Brittle nails
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decreased Muscle Mass
- ☐ Acne
- ☐ Facial Hair
- ☐ Dry Eyes
- ☐ Joint Pain
- ☐ Difficulty Sleeping
- ☐Mind Racing at Bedtime
- ☐ Stress Eating

Is there any other pertinent information that you would like to share with your provider: _____

NORTHVIEW MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of examinations, lab draws, and insertion of pellets or other procedures in relation to BioTe, where warranted, on me (or on the patient named below, for whom I am legally responsible for) by the practitioner named below and/or other licensed doctors who now or in the future work at the clinic or office listed below:

Amanda Tanner, CNM-APRN

I have had an opportunity to discuss with the practitioner named the nature and purpose of procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine there are some risks to treatment I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. The practitioner named above has additionally explained the risks associated with my refusal of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Informed Consent for Conservative Care

To the patient: You have a right to be informed about your condition, the recommended treatment, and the potentiality of any risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

___I understand that the Provider will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner.
___ I understand that the Provider may be prescribing medications but will not be giving any advice about medications that I am currently taking. All medication advice is referred to your pharmacist and primary provider.
___ I understand that there are some risks to the insertion of pellets including, but not limited to: increased symptoms and pain, no improvement of symptoms or pain.
I have read, or have had read to me, the above consent. By signing below, I consent to the initial visit. I intend this consent form to cover the entire course of my treatment for my current condition.

To be completed by the patient:

_____
Printed name

_____
Signature

_____
Date Signed

_____
Witness/Date

To be completed by the patient's representative (if applicable):

_____
Patient's Name

_____
Name of Representative

_____
Rep's Signature / Relationship

_____
Date Signed

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance, health plan, or medical benefits I have), I am ultimately responsible to pay Northview Medical Clinic, as well as all licensed professionals, employees, employers, representatives, and agents thereof; as well as all laboratories, pharmacies, clinics, hospitals, and equipment suppliers used by or referred by Northview Medical Clinic or by any of the forgoing (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, equipment, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. It is also my intention that Healthcare Provider shall possess any and all anti-retaliation protections that I may have under 29 U.S.C. § 1140 whenever Healthcare Provider is exercising my rights or acting on my behalf, or as my assignee, in anyway whatsoever.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing, and in such case, can only be revoked for future services, test, etc. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____
Printed name

_____
Signature

_____
Date Signed

_____
Witness/Date

If applicable:

_____
Patient's Name

_____
Name of Representative

_____
Rep's Signature / Relationship

_____
Date Signed