

Female Initial Health Assessment & Consents



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:

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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) | <input type="checkbox"/> |
| Sleep Problems (difficulty falling asleep or sleeping through the night) | <input type="checkbox"/> |
| Irritability (mood swings, feeling aggressive, angers easily) | <input type="checkbox"/> |
| Anxiety (feeling overwhelmed feeling panicky, or feeling nervous) | <input type="checkbox"/> |
| Decline in drive or interest (loss of "zest for life", feeling sad or down) | <input type="checkbox"/> |
| Joint and/or muscular symptoms (joint pain, muscle weakness, poor recovery after exercise) | <input type="checkbox"/> |
| Difficulties with memory (concentration, finding the right word, or retaining information) | <input type="checkbox"/> |
| Vaginal dryness or pain with intercourse | <input type="checkbox"/> |
| Sexual problems (changes in desire, activity, orgasm and/or satisfaction) | <input type="checkbox"/> |
| Hot Flashes (burst that starts in chest and lasts for short duration) | <input type="checkbox"/> |
| Sweating (night sweats or increased episodes of sweating) | <input type="checkbox"/> |
| Hair loss (rapid or thinning) | <input type="checkbox"/> |
| Feeling cold all the time, having cold hands and/or feet | <input type="checkbox"/> |
| Headaches or migraines (increase in frequency or intensity) | <input type="checkbox"/> |
| Weight (difficulty losing weight despite diet and exercise) | <input type="checkbox"/> |
| Bladder problems (difficulty in urinating, increased frequency or urgency) | <input type="checkbox"/> |

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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

Medical History:

Please select all that 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
- Prostate enlargement (BPH)
- HIV
- Hepatitis
- Hemochromatosis
- Pancreatitis or History of Pancreatitis
- History of Gall Bladder Disease
- Polycythemia Vera (PV)

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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 that you are currently taking with the dose?

Family History:

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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

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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 of this document is to be considered as valid and as enforceable as the original.

Printed name

If applicable:

Signature

Patient's Name

Date Signed

Name of Representative

Witness/Date

Rep's Signature / Relationship

Date Signed