FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

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 down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

NORTHVIEW MEDICAL

7356 Stockman Street Cheyenne, WY 82009

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

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

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars _____ per day. ☐ I use e-cigarettes _____ a day. ☐ I use caffeine _____ a day.

☐ I drink alcoholic beverages _____ per week. ☐ I drink more than 10 alcoholic beverages a week.

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

How Did You Hear About Us?

Referral (Name):_____

Internet Magazine TV

Other:_____

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Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

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 practitioners 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 The Doctor and/or Medical Provider are offering to treat the pain and symptoms associated with the diagnoses of peripheral neuropathy, spinal disk herniations or bulge and subluxation with its associated neuromusculoskeletal conditions. The Doctor and/or Medical Provider will not offer to diagnose or treat any diseases.

___I understand that The Doctor and/or Medical 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 Doctor and/or Medical 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:

_____ *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.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

_____
(please print patient name)

X_____ (SEAL)
(signature of Guardian if applicable)