Menopause & Hormone
Specialty Center

MEDICAL FORM

PERSONAL INFORMATION

Full Name : ____________________

GOES BY: ____________________

Date Of Birth : ______ / ______ / ______ **Gender** : ☐ Male ☐ Female

Ethnicity: ____________________ **Preferred Language:** ____________________

Address : ____________________

Work Phone : ____________________ **Cell Phone** : ____________________

Home Phone : ____________________ **Phone Preference** : ____________________

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Occupation : ____________________ **Are You A Retiree ?** : ☐ Yes ☐ No

Email: ____________________

Notes: ____________________

EMERGENCY CONTACT DETAILS

Contact Name : ____________________ **Home Number** : ____________________

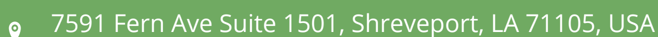
Relationship : ____________________ **Mobile Number** : ____________________

DOCTOR INFORMATION

Primary Care Physician : ____________________ **Phone** : ____________________

Gynecologist : ____________________ **Phone** : ____________________

More Information :


7591 Fern Ave Suite 1501, Shreveport, LA 71105, USA

(318) 524-8032
Fax: (318) 524-8033

www.menopausehormonecenter.com

THANK YOU

Menopause & Hormone
Specialty Center

INSURANCE INFO

PERSONAL INFORMATION

Full Name :

Primary Insurance :		**Member ID** :	
Group ID :		**Subscriber Name** :	
Subscriber DOB :			
Secondary Insurance :		**Member ID** :	
Group ID :		**Subscriber Name** :	
Subscriber DOB :			

More Information :

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THANK YOU

CURRENT MEDICATION

PERSONAL INFORMATION

Full Name :

Date Of Birth : ______/______/______

Medication Name	Strength	Frequency	Condition	Notes

Pharmacy

Have you ever had any reactions to any medications? ______________________

____

More Information :

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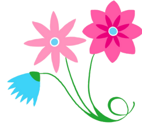
THANK YOU



Menopause & Hormone
Specialty Center

MEDICAL HISTORY

PAGE 1

Full Name : ____________________

Date Of Birth : ________ / ________ / ________

Have you ever had any issues with anesthesia? : ____________________

Current Hormone Replacement Therapy : ____________________

Past Hormone Replacement Therapy : ____________________

Current Vitamins

Current Supplements

Surgeries & Dates

Misc.

Last Menstrual Period Estimated year if Unknown ____________________

Do you have any Allergies? ____________________

____

More Information :

Fax: (318) 524-8033

THANK YOU

MEDICAL HISTORY

Full Name : ______________________

Date Of Birth : ________ / ________ / ________

PREVENTATIVE MEDICAL CARE

- ☐ Pap Smear Date: ____________
- ☐ Mammogram Date: ____________
- ☐ Bone Density Date: ____________
- ☐ Pelvic Ultrasound Date: ____________

HIGH RISK PAST MEDICAL/SURGICAL HISTORY

- ☐ Breast Cancer: ____________
- ☐ Uterine Cancer: ____________
- ☐ Ovarian Cancer: ____________
- ☐ Hysterectomy w/ Ovary Removal: ____________
- ☐ Hysterectomy Only: ____________
- ☐ Oophorectomy Removal: ____________

BIRTH CONTROL METHOD

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Birth Control Pills
- ☐ Vasectomy
- ☐ Other

MEDICAL ILLNESS

- ☐ High Blood Pressure
- ☐ Heart Bypass
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Blood Clot
- ☐ Pulmonary Emboli
- ☐ Arrhythmia
- ☐ Any form of Hepatitis
- ☐ HIV
- ☐ Lupus
- ☐ Auto Immune Disease
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Disorder
- ☐ Cancer: ____________ type ____________ year
- ☐ Chronic Liver Disease (hepatitis, fatty liver, cirrhosis)
- ☐ Trouble passing Urine or take Flomax/Avodart

More Information :

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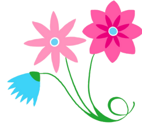


SYMPTOM REVIEW 1

Mark only those of which you have.

Full Name :

Date Of Birth : ____________/____________/____________

NOSE

- [ ] Altered Sense of Smell
- [ ] Nose Bleeds
- [ ] Postnasal Drip
- [ ] Sinus Pain/Pressure

EARS

- [ ] Hearing Loss
- [ ] Ear Pain
- [ ] Drainage
- [ ] Ringing in Ears

EYES

- [ ] Blurred Vision
- [ ] Double Vision
- [ ] Eye Pain
- [ ] Change in Vision
- [ ] Glaucoma

SKIN, HAIR, NAILS

- [ ] Rash
- [ ] Skin Change
- [ ] Nail Changes
- [ ] Excessive Sweating

GENERAL

- [ ] Fever/Chills
- [ ] Fatigue
- [ ] Night Sweats
- [ ] Weight Change
- [ ] Headaches
- [ ] Dizziness
- [ ] Loss of Consciousness
- [ ] Head Injury

GASTROINTESTINAL

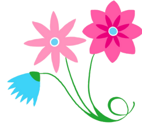
- [ ] Loss of Appetite
- [ ] Painful Swallowing
- [ ] Heartburn
- [ ] Nausea
- [ ] Headaches
- [ ] Vomitting
- [ ] Constipation
- [ ] Diarrhea

WOMEN'S HEALTH

- [ ] Age at first Period
- [ ] Painful Cycles
- [ ] Irregular Cycles
- [ ] Vaginal Dryness
- [ ] Bleeding Between Cycles
- [ ] Vaginal Irritation/Itching
- [ ] Libido Change
- [ ] Number of Pregnancies
- [ ] Thyroid Disease
- [ ] No. of Miscarriages/Abortions
- [ ] History of C-Sections
- [ ] Premature Deliveries
- [ ] Use of Birth Control

ENDOCRINE

- [ ] Thyroid Enlargement
- [ ] Hot/Cold Intolerance
- [ ] Increased Urination
- [ ] Increased Thirst
- [ ] Increased Appetite
- [ ] Changes in Facial/Body Hair



SYMPTOM REVIEW 2

Mark only those of which you have.

Full Name :

Date Of Birth : ______ / ______ / ______

GENITOURINARY

- [ ] Painful Urination
- [ ] Increased Urination Frequency
- [ ] Nighttime Urination
- [ ] Incontinence

THROAT & MOUTH

- [ ] Hoarseness
- [ ] Sore Throat
- [ ] Toothache
- [ ] Tongue Swelling
- [ ] Ulcers
- [ ] Taste Disturbance

RESPIRATORY

- [ ] Pain w/ Breathing
- [ ] Wheezing
- [ ] Cough
- [ ] Sputum
- [ ] Coughing up Blood

PSYCHIATRIC

- [ ] Depression
- [ ] Mood Changes
- [ ] Difficulty Concentrating
- [ ] Suicidal Thoughts
- [ ] Sleep Disturbances
- [ ] Anxiety

MUSCULOSKELETAL

- [ ] Joint Pain/Stiffness
- [ ] Restricted Motion
- [ ] Swelling
- [ ] Bone Deformity

LYMPH NODES

- [ ] Enlargement/Tenderness

HEMATOLOGIC/BLOOD

- [ ] Anemia
- [ ] Bruise Easily
- [ ] Transfusion HIstory
- [ ] Blood Cell Disorder

HEART & CIRCULATION

- [ ] Chest Pain
- [ ] Palpitations
- [ ] Exercise Intolerance
- [ ] Leg Swelling
- [ ] History of Heart Attack
- [ ] High Blood Pressure

MISC. FORM

PERSONAL INFORMATION

Full Name

DO YOU STILL HAVE YOUR UTUERUS? ☐ yes ☐ no

DO YOU STILL HAVE YOUR OVARIES? ☐ yes ☐ no AGE OF OVARY REMOVAL ____

CONTRACEPTION/BIRTH CONTROL USED ☐ yes ☐ no TYPE ____

NUMBER OF PREGNANCIES ____ LIVING CHILDREN ____ PREMATURE BIRTHS ____

ABORTIONS ____ MISCARRIAGES ____

What menopausal symptoms are you experiencing? ____

List parents & siblings, their ages, if they passed away, and cause of death. Also, list family members who have passed due to cancer (and what type) ____

List medications of your close family members who have the same symptoms, taken the same meds, with same results. ____

Health Problems ____

SOCIAL

☐ I am Sexually Active

☐ I want to be Sexually Active

☐ I have completed my family.

☐ My sex has suffered.

☐ I haven't been able to orgasm.

HABITS

☐ Smoke Cigarettes or Cigars ____ per. ____ day.

☐ Drink Alcoholic Beverages per. ____ day.

☐ Drink more than 10 alcoholic beverages per week.

☐ Use Caffeine ____ day.

☐ Use Drugs ____ times a day. Type(s) of drug: ____

Patient/Guardian Signature ____ Date : ____

Reviewed by Physician ____ Date : ____

HORMONE CONSENT

CONSENT FOR HORMONE REPLACEMENT THERAPY

:

I, ______________________________ give Tammi Herkey, WHNP-C and Menopauses specialist permission to prescribe me any hormone regiment that will make me feel better, relieve my symptoms and improve my quality of life. I have no history of breast cancer and no history of heart disease.

I, ______________________________ have a history of heart disease but my cardiologist gives me permission to take hormone replacement therapy. I shall provide a note from cardiologist stating it is okay to take hormone replacement therapy.

I, ______________________________ have had breast cancer but my oncologist allows me to take vaginal estrogen therapy only and testosterone and progesterone in any form. Provide a note from oncologist stating it is okay for her to take for her to take hormones testosterone and/or progesterone and only vaginal estrogen therapy.

I, ______________________________ will not hold Tammi Herkey WHNP-C and Menopause Specialist liable if after taking HR (Hormone Replacement Therapy) should I develop breast cancer or heart disease. It is my choice to take the medications and in no way I was forced to HRT.

______________________________ ______________________________

PRINT: Patient/Guardian Name **SIGN: Patient/Guardian Name**

______________________________ ______________________________

PRINT: Provider Name **SIGN: Provider Name**

Date ____________________ :

Date ____________________

TREATMENT CONSENT 1

CONSENT FOR TREATMENT WITHOUT DIRECT SUPERVISION BY A PHYSICIAN

:

This consent serves as notice that care given at the Menopause and Hormone Specialty Center, LLC is not done so under the "direct supervision" of a physician, and there is no physician located on site responsible for the evaluation and management decisions made.

While the Menopause and Hormone Specialty Center, LLC is responsible for your test results, you are to be advised that these results, including blood tests, mammograms, and any other diagnostic tests performed during the course of your treatment will not be routinely reviewed by, nor the validity of the results verified by, the collaborative physician.

Signing this consent gives Tammi Herkey, MS, APRN, WHNP-C, CMC the right to treat your hormone specific needs under the scope of her practice and specialized training, without direct supervision by a physician, and releases the collaborative physician of liability for any treatment outcome or test result provided without specific request for interpretation and collaboration.

PRINT: Patient/Guardian Name

SIGN: Patient/Guardian Name

PRINT: Provider Name

SIGN: Provider Name

PRINT: Witness Name

SIGN: Witness Name

TREATMENT CONSENT 2

CONSENT FOR TREATMENT

:

I consent to services, treatment, and diagnostic procedures; including, but not limited to medications, lab tests, and other studies which may be ordered by my physician at Menopause Hormone Specialty Center, LLC. I have the right to ask questions and receive information about any services that I may receive.

____

Patient/Guardian Signature

____

PRINT NAME

____

Date

THYROID CONSENT

POTENTIAL RISK WHEN TAKING THYROID MEDICATIONS FOR HYPOTHYROIDISM

:

DATE ______________________________

When taking thyroid medications it is very important that you are monitored closely. Having serum levels checked every 3-6 months.

When taking thyroid medications for hypothyroidism you can be at risk of hyperthyroid if your serum levels are too high.

If this occurs you are at risk of:
Heart Problems - rapid heart rate, atrial fibrillation, and congestive heart failure
Brittle Bones - osteopenia or osteoporosis
Eye Problems - red or swollen eyes, sensitivity to light, visual changes
Thyrotoxic Crisis - sudden intensification of your symptoms, leading to fever, rapid pulse, and even delirium. If this occurs, seek immediate medical attention.

If you are currently on Synthroid, Cytomel, or Armour Thyroid prescribed by me and desire to continue to do so, please sign the consent below. By signing this consent you are taking full responsibility of any potential risks that may occur with you taking medications for your hypothyroidism.

______________________________ ______________________________
PRINT: Patient/Guardian Name **SIGN: Patient/Guardian Name**

______________________________ ______________________________
PRINT: Provider Name **SIGN: Provider Name**

______________________________ ______________________________
PRINT: Witness Name **SIGN: Witness Name**

HIPAA FORM

HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

:

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information I understand that this information can and will be used to:

- Obtain payment at the time of your visit."
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, bit if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient/Guardian Signature

PRINT NAME

Date

Menopause & Hormone
Specialty Center

PATIENT REQUEST

PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION AND DISCLOSURE

Patient Name ______________________________

Patient Address ______________________________

City ____________________ **State** __________ **ZIP** __________

Date of Birth ____________________ **Social Security** ____________________

Please consider this request for me to exercise my rights under federal and state law to request confidential communication of my protected health information.

Please explain below whom, specifically, you want to grant the use of your protected health information:

Name of Person(s)	Relationship

I understand that the physician (or provider) to whom I am making this request will make responsible efforts to accommodate this request. I understand that the physician (or provider) is not required to honor this request when information about me is needed for emergency treatment or in various instances when the information is permitted, by law, to be released. I further understand that the physician (or provider) may terminate this restriction and I will be informed of the termination. I may also choose to terminate this restriction and may do so orally or in writing.

____

Patient/Guardian Signature

____

Date

CONTACT US

CONTACT ACKNOWLEDGEMENT

:

E-mail Guidelines:
The staff of Menopause and Hormone Specialty Center, LI.C welcomes your contact. We also value your privacy and time and therefore offer the following information to help you decide on the best method for reaching us. We hope that these guidelines are helpful to you as you decide how best to reach our staff. We take your time and confidentiality very seriously and therefore consider it imperative that you understand the limitations of our use of e-mail technology.

- When we respond to your e-mail, we will respond to the address from which it is sent. If you do not wish others who may have access to the e-mail account you are using to also have access to our response, please consider another means of communication.

On-line Medical Advice:
Unfortunately, e-mail is not an appropriate medium for medical advisement, so if there is ever an issue of not understanding, please e-mail us back and ask us to clarify, or try another means of communication or call our office and schedule an appointment for Medical Advice.

How quickly can you expect a reply?
While we try to check our e-mail regularly, you have no way of knowing if one of us is unavailable due to illness, vacation, or other reasons, or if there are problems with the network itself. This means that your message may not be received immediately.

Contact:
If time is of particular concern for you, you should consider calling our office at (318)-524-8032.

E-mail Address:

I understand that e-mailing information to and from Menopause and Hormone Specialty Center, LLC may not be the most secure way of communicating; However, I give Menopause and Hormone Specialty Center, LIC permission to e-mail me regarding appointment scheduling, lab results, prescription refills, or anything else regarding my care at the office.

PRINT: Patient/Guardian Name	**SIGN: Patient/Guardian Name**
Best Email To Contact You	**Email Address #2**
Witness Signature	**Date**

Menopause & Hormone
Specialty Center

CANCEL APPOINTMENT

APPOINTMENT CANCELLATION & RESCHEDULING

:

This notice is to inform you that if you do not give us 24 hour notice of your appointment needing to be rescheduled there will be a $25.00 fee for not cancelling your appointment 24 hours in advance.Signing this form makes you accountable for your appointments and enables me to bill you for the $25.00 fee.

When you no show or cancel the day of your appointment it prevents us from seeing another patient in your slot that has been waiting to see me. Please note, I am having to do this because of an increase of patients no showing or cancelling their appointment the day it is scheduled for

.

Thanks for your co-operation in this matter.

Sincerely,

Tammi K. Herkey, Owner

Patient/Guardian Signature

PRINT NAME

Date