Dear Patient:

You've made the right choice towards getting your life back on track. Pellets are a superior and remarkable method of Bio-Identical Hormone Replacement Therapy (BHRT). This type of therapy has been documented and researched in medical journals since 1939. Not only will you regain the energy, libido and vitality of your youth; we are here to help you get back to your normal physiological state of well-being. *Won't that be a welcome relief?*

Your appointment is scheduled on:

Day & Date:_____ Arrival Time: _____ Time: _____

Provider: Christopher Neary ND, MSOM Location: Riverside Wellness

Please notify us 48 hours in advance of a cancellation

Inside your packet, we've enclosed many pages for you to fill out and ones filled with information.

Lab work: Please go to the lab location we have provided for you *within the next few days* to ensure that your lab results are available by your scheduled appointment date. Please check with your insurance carrier prior to receiving your lab work to find out if your insurance covers the lab work. If you have a high deductible or your insurance does not cover your lab work, please call your provider's office price ranges. This is a fasting test; please fast for 8-10 hours before your lab work.

Special Note: If you are a Medicare/HMO patient, it is important that you ask your current Medicare/HMO provider to complete their lab form with our necessary lab work. Medicare/HMO may or may not cover your lab work charges. In addition, **please complete all the enclosed new patient forms and bring them with you to your appointment.**

Pages to fill out and bring with you to your appointment. Please do not put them in the mail or fax.

- ☐ **Female Patient Questionnaire**
- ☐ **Patient Consent to Leave Detailed Message**
- ☐ **Medicare Non-Assigned Form** (if applicable)
- ☐ **Authorization for Release of Information**
- ☐ **Acknowledgement Form**

Along with a copy of your most recent: ☐ **Mammogram** ☐ **Pap** ☐ **Bone Density** (if possible)

We are committed to making sure your treatment and visits with us are as positive as they can be. We understand you are a unique individual and we strive to provide you with the highest quality medical care. Our primary concern is to restore you to a state of "well-being" and optimum health! Our patients are treated with compassion and respect. We encourage you to openly express your needs and concerns to our staff.

We look forward to seeing you soon.

Here's to your well-being!

FEMALE PATIENT INFORMATION

Name: _____ Today's Date: MM/DD/YYYY

LAST FIRST MIDDLE

Date of Birth: MM/DD/YYYY

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone:

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _____

LAST FIRST MIDDLE

Spouse's Date of Birth MM/DD/YYYY

Spouse's Employer:

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____

Contact Information: _____

HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: MM/DD/YYYY

What is the reason for your visit today? Please describe the symptoms & be specific:

How did you hear about us:

SYMPTON CHECKLIST

Please indicate how often you have the following

Night sweats:	☐ Frequently	☐ Rarely	☐ Never
Hot flashes/hot flushes:	☐ Frequently	☐ Rarely	☐ Never
Pain with intercourse:	☐ Frequently	☐ Rarely	☐ Never
Vaginal dryness:	☐ Frequently	☐ Rarely	☐ Never
Sleeping problems:	☐ Frequently	☐ Rarely	☐ Never
Urine leaks when you cough or sneeze:	☐ Frequently	☐ Rarely	☐ Never
Decrease in physical sensation during intercourse	☐ Frequently	☐ Rarely	☐ Never
Feel air flowing from your vagina	☐ Frequently	☐ Rarely	☐ Never
Tampons feel like they are slipping out	☐ Frequently	☐ Rarely	☐ Never
Difficulty concentrating/memory loss:	☐ Frequently	☐ Rarely	☐ Never
Mood swings:	☐ Frequently	☐ Rarely	☐ Never
Migraines:	☐ Frequently	☐ Rarely	☐ Never
Depression:	☐ Frequently	☐ Rarely	☐ Never
Anxiety:	☐ Frequently	☐ Rarely	☐ Never
Decrease in sexual desire:	☐ Frequently	☐ Rarely	☐ Never
Decrease in energy level:	☐ Frequently	☐ Rarely	☐ Never
Loss of memory:	☐ Frequently	☐ Rarely	☐ Never
Foggy thinking:	☐ Frequently	☐ Rarely	☐ Never
Muscle and/or joint pain:	☐ Frequently	☐ Rarely	☐ Never

Please check the boxes below if they apply to how you have dealt with the above symptoms

Herbal medications/supplements ☐ YES ☐ NO

Please specify how: _____

Change of diet: ☐ YES ☐ NO

Please specify how: _____

Layered clothing: ☐ YES ☐ NO

Please specify how: _____

Increase exercise: ☐ YES ☐ NO

Please specify how: _____

Other: _____

_____

_____

GYN HISTORY

Are you sexually active: ☐ YES ☐ NO

Have you been sexually active: ☐ YES ☐ NO

Do you have pain with intercourse: ☐ YES ☐ NO

What type of contraception are you currently using (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

What type of contraception have you used in the past (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

Are you having any problems with your method of birth control: ☐ YES ☐ NO

Have you ever had any vaginal, cervical and/or tubal infection: ☐ YES ☐ NO

If yes, please check below call that apply:

☐ Gardnerella ☐ Syphilis ☐ Condyloma ☐ Bacterial Vaginitis

☐ Yeast ☐ PID ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Warts

☐ Other: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear ☐ YES ☐ NO

If yes, how was it treated (please check below all that apply):

☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy

☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Excition

Have you ever had cervical cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had uterine cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had ovarian cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have trouble leaking urine: ☐ YES ☐ NO

Do you have any breast lumps, tenderness or discharge: ☐ YES ☐ NO

Have you ever had a mammogram: ☐ YES ☐ NO

If yes, was it normal: ☐ YES ☐ NO

Date of last mammogram: _____

Do you do self breast exams: ☐ YES ☐ NO

Do you have PMS symptoms: ☐ YES ☐ NO

If yes, are you currently undergoing treatment: ☐ YES ☐ NO

If yes, what type of treatment: _____

Do you have any uterine abnormality: ☐ YES ☐ NO

Do you have a history of infertility: ☐ YES ☐ NO

Do you have a history of DES exposure ☐ YES ☐ NO

Do you have fibroids of the uterus: ☐ YES ☐ NO

Have you had abnormal bleeding in the past year: ☐ YES ☐ NO

If yes, please describe: _____

At what age did you start menopause: _____

MENSTRUAL HISTORY

If you no longer have periods, please check reason

☐ Natural ☐ Hysterectomy ☐ Ablation ☐ Menopause

Do you have a uterus: ☐ YES ☐ NO

First day of last period: _____

Typically, how many days do your periods last: _____

Are your periods regular: ☐ YES ☐ NO

How many days are between the start of your periods: _____

Has the flow of your period changed in any way: ☐ YES ☐ NO

If yes, please explain the change: _____

Does bleeding occur between your normal period cycle: ☐ YES ☐ NO

Do you suffer from cramps during your periods: ☐ YES ☐ NO

If yes, please check the pain associated with the cramps:

☐ MILD ☐ MODERATE ☐ SEVERE

What medicine, if any, are you currently taking for your cramps: _____

SOCIAL HISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please try list the number you smoke per day on average: _____

Please list the number of years you have been smoking: _____

Do you use recreational drugs: ☐ YES ☐ NO

Do you drink alcohol: ☐ YES ☐ NO

If yes, what type of alcohol do you drink: _____

How many drinks **per week** , on average, do you drink: _____

Are you using any form of Testosterone or Hormone Therapy: ☐ YES ☐ NO

If yes, please check which type:

☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

MEDICAL HISTORY

Do you have **diabetes**: ☐ YES ☐ NO

Do you have or have you ever had **hypertension**: ☐ YES ☐ NO

Do you have **heart disease**: ☐ YES ☐ NO

Have you ever had a **heart attack**: ☐ YES ☐ NO

Have you ever had a **stroke**: ☐ YES ☐ NO

Do you have a **heart murmur**: ☐ YES ☐ NO

Do you have or have you ever had **kidney disease**: ☐ YES ☐ NO

Have you ever been treated for a **psychiatric disorder**: ☐ YES ☐ NO

If yes, please name the disorder: _____

Have you ever had **rheumatic fever**: ☐ YES ☐ NO

Do you have **mitral valve prolapse**: ☐ YES ☐ NO

Have you ever had a **urinary tract infection**: ☐ YES ☐ NO

Have you ever had **hepatitis**: ☐ YES ☐ NO

If yes, please check which type:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had **liver disease**: ☐ YES ☐ NO

Have you ever had **varicose veins**: ☐ YES ☐ NO

Have you ever had **phlebitis**: ☐ YES ☐ NO

Do you have any **thyroid problems**: ☐ YES ☐ NO

If **yes,** please check the problem

☐ Low Function ☐ Overactive ☐ Goiter ☐ Hashimoto's

Have you ever had a **blood transfusion**: ☐ YES ☐ NO

Do you have **asthma**, **emphysema** or **chronic bronchitis**: ☐ YES ☐ NO

Do you have or have you ever had **leukemia**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **lymphoma**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **colon cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **colon polyps**: If ☐ YES ☐ NO

yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **multiple myeloma**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **lung cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **rectal cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **breast cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment

☐ Lumpectomy ☐ Mastectomy ☐ Radiation Therapy ☐ Chemotherapy

Do you have any **drug allergies**: ☐ YES ☐ NO

If yes, please list the drugs you are allergic to:

_____

Please list **all** major surgeries (including year and reason):

_____

_____

_____

Please list any other operations/hospitalizations (including year and reason):

_____

_____

Have you ever had any anesthesia complications: ☐ YES ☐ NO

If yes, please explain:

_____

Are you currently or have you ever been **anemic**: ☐ YES ☐ NO

Do you have an Internist or Family Physician: ☐ YES ☐ NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____

Are you currently taking any medications: ☐ YES ☐ NO

Please list the medications your are currently taking and the dosage amount:

_____

_____

_____

Have you ever had your cholesterol checked: ☐ YES ☐ NO

If yes, what was the date it was last checked: _____

How was your cholesterol: ☐ Low ☐ Normal ☐ High

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Do you have **lupus**: ☐ YES ☐ NO

Do you have **scleroderma**: ☐ YES ☐ NO

Do you have **rheumatoid arthritis**: ☐ YES ☐ NO

Have you had **blood clots in your legs or lungs**: ☐ YES ☐ NO

Do you have problems with **water retention**: Do ☐ YES ☐ NO

you have problems with **swelling**: ☐ YES ☐ NO

Do you have problems with **bloating**: ☐ YES ☐ NO

Do you have **osteopenia**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have **osteoporosis**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you suffer from **hair loss**: ☐ YES ☐ NO

Do you suffer from or have you had **acne**: ☐ YES ☐ NO

FAMILY HISTORY

Do you have a family history of **breast cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **colon cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **ovarian cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **osteoporosis**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **diabetes**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **hypertension**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **heart disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **kidney disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

At what age did your mother go though menopause: _____

Symptom Questionnaire

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0= you never experience the symptom
5= you experience the symptom severely and all the time

Dermatological

Dry Skin	__/5
Course Skin	__/5
Itchy Skin	__/5
Dry, course hair	__/5
Thinning/loss of hair	__/5
Thinning eyebrows	__/5
Brittle or ridges on nails	__/5
Excess wax in ears	__/5
Decreased sweat	__/5
Paleness of skin or lips	__/5
TOTAL	**__/50**

Metabolism

Lethargy (low energy)	__/5
Sensation of cold	__/5
Heat intolerance (not hot flashes)	__/5
Slow speech (non memory)	__/5
Weight gain with little food intake	__/5
Lack of appetite	__/5
Lack of libido	__/5
TOTAL	**__/30**

Dryness (sicca)

Dry eyes	__/5
Dry skin	__/5
Dry mouth	__/5
Dry nose	__/5
Dry sinuses	__/5
Dry vagina	__/5
TOTAL	**__/30**

Gastrointestinal

Constipation	__/5
Diarrhea	__/5
Irritable bowel syndrome	__/5
GERD (reflux disease)	__/5
TOTAL	**__/20**

Reproductive

Delayed menstrual flow	__/5
Excessive menstrual flow	__/5
Painful menses	__/5
Impotence (men only)	__/5
TOTAL	**__/20**

Mental/Emotional Well-being

Depression	__/5
Irritability/mood swings	__/5
Nervousness	__/5
Anxiety	__/5
Impaired memory	__/5
Impaired focus	__/5
TOTAL	**__/30**

Cardiovascular/Respiratory

Chest pain	__/5
Palpitations	__/5
Atrial fibrillation	__/5
Chronic cough of *unknown reason*	__/5
Airflow obstruction (non smokers)	__/5
Shortness of breath on physical exertion	__/5
Shortness of breath in general	__/5
TOTAL	**__/30**

Swelling

Swollen ankles	__/5
Swollen wrists	__/5
Swollen eyelids	__/5
Swollen, thick tongue	__/5
Swollen face	__/5
TOTAL	**__/25**

Musculoskeletal

Muscle weakness	__/5
Unexplained tingling or Numbness	__/5
Body aches	__/5
Muscle pain	__/5
Joint pain	__/5
Carpal tunnel syndrome	__/5
Plantar fasciitis	__/5
TOTAL	**__/35**

Sleep

Difficulty getting to sleep	__/5
Difficulty staying asleep	__/5
Wake unrefreshed	__/5
Sleep apnea	__/5
Snoring	__/5
TOTAL	**__/25**

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
__Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
__Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
__Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)

Female Hormone Symptom Diary Name: _____

SYMPTOMS: Rate 1-10 (10 is the worst)	Before Treatment Date:	Month #1 Date:	Month #2 Date:	Month #3 Date:	Month #4 Date:	Month #5 Date:	Month #6 Date:
Fatigue							
Insomnia							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Depression							
Anxiety							
Muscle Weakness							
Migraine Headaches							
Hair Loss							
Dry Skin							
Facial Hair							
Nausea							
Muscle Pain							
Joint Pain							
Foggy Mind							
Loss of Well Being							
Poor Results from Exercise							
Painful Intercourse							
Vaginal Dryness							
Night Sweats							
Hot Flashes							