PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name (Print) _____

Signature _____ Date _____

Guy's
INNOVATIVE PHARMACY SERVICES
"Your Complete Wellness Solution"

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ips@guyspharmacy.com

Medical History

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(W)** _____ **(C)** _____

Email: _____

Gender: □ **Female** □ **Male** **Height:** _____ **Weight:** _____

SSN: _____

			How often and how much?
Do you use tobacco?	□ Yes	□ No	_____
Do you use alcohol?	□ Yes	□ No	_____
Do you use caffeine?	□ Yes	□ No	_____

Doctor's Name: **Clinic Name:**

_____

_____

_____

Allergies: (Please check all that apply)

□ Penicillin	□ Morphine	□ Dye allergies	□ Pet allergies
□ Codeine	□ Aspirin	□ Nitrate allergy	□ Seasonal (pollen)
□ Sulfa drugs	□ Food allergies	□ Lactose	□ No known allergies

□ Other (please list): _____

Please describe the allergic reaction you experienced and when it occurred?

_____

_____

Over-the-counter (OTC) issues:

Please check all products that you use regularly. (Please check all that apply)

- ☐ Pain reliever
- ☐ Aspirin
- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Ketoprofen
- ☐ Cough Suppressant
- ☐ Antihistamine
- ☐ Decongestant
- ☐ Sleep Aids
- ☐ Antidiarrheals
- ☐ Laxative/Stool softner
- ☐ Diet aids/weight loss
- ☐ Antacids
- ☐ Acid blockers
- ☐ Other (please list): _____

Nutritional/Natural Supplements: Please list the products you are taking and if possible give a photocopy of the ingredients on the label.

_____

_____

_____

_____

_____

Medical Conditions/Diseases: (Please check all that apply)

- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Cancer
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Lung conditions
- ☐ Blood clotting problems
- ☐ Diabetes
- ☐ Depression
- ☐ Arthritis or joint problems
- ☐ Epilepsy
- ☐ Headaches/migraines
- ☐ Eye disease (glaucoma etc)
- ☐ Other: (Please list)

_____

_____

Current Prescription Medications:

Medication Name	**Strength**	**Date Started**	**How often per day**

List Hormones previously taken Date Started Date Stopped Reason

_____

_____

_____

_____

Have you ever used oral contraceptives? □ No □ Yes

Any Problems? □ No □ Yes

If Yes, describe any problem(s): _____

_____

How many pregnancies have you had? _____ **How many children?** _____

Any interrupted pregnancies? □ No □ Yes

Have you had a hysterectomy? □ No □ Yes Date of surgery _____

Ovaries removed? □ No □ Yes

Have you had a tubal ligation? □ No □ Yes Date of surgery _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	_____
Ovarian Cancer	_____	Family member(s)	_____
Fibrocystic Breast	_____	Family member(s)	_____
Breast Cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography	□ No	□ Yes	Date: _____
PAP Smear	□ No	□ Yes	Date: _____
Thyroid Tests			
TSH	Level: _____		Date: _____
T4	Level: _____		Date: _____
T3	Level: _____		Date: _____

Since you first began having periods, have you ever had what you would consider to be abnormal cycles? ☐ No ☐ Yes Date: _____

If Yes, Please explain (such as age when occurred, symptoms…)

_____

_____

When was your last period? _____

How many days did it last? _____

Do you have or did you ever have Premenstrual Syndrome (PMS)? ☐ No ☐ Yes

If Yes, explain symptoms: _____

_____

_____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

☐ Doctor ☐ Self ☐ Friend/Family Member ☐ Other

What are you goals with taking BHRT?

_____

_____

_____

Please write down any questions you have about BHRT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

What is your current occupation or your occupation prior to retirement?

_____

Describe your work or volunteer environment?

_____

How many hours a week do you work or volunteer?_____

Are you satisfied with your work or volunteer situation? _____

_____

Do your symptoms differ at work and at home?_____

_____

Do you have trouble getting out of bed in the morning or feel fatigued during the day?

_____

_____

Who lives in your household? _____

_____

Describe your living environment? _____

_____

How many hours of sleep do you get a night? _____

How would you describe the quality of sleep you get? _____

_____

How often do you eat out? _____

How would you describe your diet? _____

_____

Do you have an exercise routine? _____

What does it consist of? _____

_____

RATING OF SYMPTOMS

Please circle the number best describing your symptoms. 1 being Extremely Mild and 10 being Extremely Severe.

Hot Flashes	1	2	3	4	5	6	7	8	9	10
Sleep Disturbances	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Foggy Thinking	1	2	3	4	5	6	7	8	9	10
Heart Palpitations	1	2	3	4	5	6	7	8	9	10
Painful Intercourse	1	2	3	4	5	6	7	8	9	10
Low Libido	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness/atrophy	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Memory Lapses	1	2	3	4	5	6	7	8	9	10
Yeast infections	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Bone Loss	1	2	3	4	5	6	7	8	9	10
Water Retention	1	2	3	4	5	6	7	8	9	10
Breast Swelling and Tenderness	1	2	3	4	5	6	7	8	9	10
Craving for Sweets	1	2	3	4	5	6	7	8	9	10
Fibrocystic Breasts	1	2	3	4	5	6	7	8	9	10
Uterine Fibroids	1	2	3	4	5	6	7	8	9	10
Nervousness/Anxiety/Irritability	1	2	3	4	5	6	7	8	9	10
Heavy, irregular menses	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Swollen Breasts	1	2	3	4	5	6	7	8	9	10
Cramping	1	2	3	4	5	6	7	8	9	10
Infertility	1	2	3	4	5	6	7	8	9	10
Acne	1	2	3	4	5	6	7	8	9	10
PMS	1	2	3	4	5	6	7	8	9	10
Joint Pain	1	2	3	4	5	6	7	8	9	10
Somnolence	1	2	3	4	5	6	7	8	9	10
Incontinence	1	2	3	4	5	6	7	8	9	10
Gastrointestinal Bloating	1	2	3	4	5	6	7	8	9	10
Muscle Weakness	1	2	3	4	5	6	7	8	9	10
General Aches/Pains	1	2	3	4	5	6	7	8	9	10
Fibromyalgia	1	2	3	4	5	6	7	8	9	10
Blunted Motivation	1	2	3	4	5	6	7	8	9	10
Diminished Feeling of Well Being	1	2	3	4	5	6	7	8	9	10
Loss of Scalp Hair	1	2	3	4	5	6	7	8	9	10
Insomnia	1	2	3	4	5	6	7	8	9	10