

NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability.

Date _____

Patient Name _____ Birth Date _____

Home Phone _____ Work or Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip Code _____

How did you hear about us? _____

Describe your main complaint(s) _____

If your complaint is due to pain, complete the following:

Location _____ Severity on a scale of 1 _____ 10

Quality _____ Duration _____

Time _____ What makes it better or worse? _____

Do you have any other health concerns? _____

MEDICAL HISTORY: List any other doctors you've seen for this condition _____

Who is your current family physician? _____ Specialist? _____

Date of your last physical exam _____ When did you have your last blood tests? _____

List any diagnoses or treatments _____

List any surgeries or major illness with date of occurrence _____

Have you had any infectious diseases? _____

Have you been hospitalized for this or any condition? _____

Do you have any allergies? _____ Have you ever reacted to medications? _____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking _____

NUTRITIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements _____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

— Do you exercise? How often? _____ What type? _____

— Do you use alcohol? How often? _____ What kind? _____

— Do you smoke? How much? _____ For how long? _____ When did you quit? _____

— Do you drink coffee? _____

— Do you drink caffeinated sodas? _____

— Do you follow a specific diet? _____

— Are you concerned about your weight? Are you following a specific diet? _____

— Do you overeat? How is your appetite? _____ Do you have any reactions to foods? _____

— Do you crave sweets? Do you have any other food cravings? _____ Or aversions? _____

— Are you concerned about aging? Do you have a specific concern? _____

— Are you concerned about your appearance? Have you used any aesthetic therapies? _____

— Are you stressed or anxious? _____

— Do you or have you experienced depression? Is there any form of depression or dementia in your family? _____

— Do you suffer from insomnia or any other form of sleep abnormality? _____

— Are you concerned about memory loss? _____

— Do you practice any form of stress reduction such as meditation, tai chi or yoga? _____

— Is your relationship fulfilling? _____ How is your children's health? _____

— Do you experience fatigue? _____

DIETARY INFORMATION: Describe your daily diet _____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know _____

BIOMARKER QUESTIONNAIRE

Age _____ Sex _____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Decreasing muscle mass | <input type="checkbox"/> Slow wound healing |
| <input type="checkbox"/> Reduced strength | <input type="checkbox"/> Frequent colds or flu |
| <input type="checkbox"/> Decreased joint mobility | <input type="checkbox"/> Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis |
| <input type="checkbox"/> Increased stiffness | <input type="checkbox"/> Chronic pain or inflammation |
| <input type="checkbox"/> Reduced capacity for work and exercise | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Decreased endurance | <input type="checkbox"/> Waking up tired |
| <input type="checkbox"/> Significant weight loss | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Increased body fat | <input type="checkbox"/> Longer recovery time needed after exertion |
| <input type="checkbox"/> Increased waist to hip ratio (more fat deposits on the abdomen and waist) | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Reduced sexual drive and/or performance | <input type="checkbox"/> Increasing difficulty concentrating |
| <input type="checkbox"/> Muscle mass loss or flabbiness | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Changes in body temperature | <input type="checkbox"/> Unexplained depression |
| <input type="checkbox"/> Sensitivity to cold or heat | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Increased anger or irritability |
| <input type="checkbox"/> Dryer or thinning skin and hair | <input type="checkbox"/> Sensitivity to certain foods |
| <input type="checkbox"/> Brown or red spots | <input type="checkbox"/> Craving for sugar |
| <input type="checkbox"/> Spider veins on the skin | <input type="checkbox"/> Alcohol intolerance |

Have you had any of the following tests?

- | | |
|--|--|
| <input type="checkbox"/> Complete Blood Count | <input type="checkbox"/> Homocysteine |
| <input type="checkbox"/> Chemistry Panel | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> PSA (Prostate Specific Antigen) and prostate exam for men over 40 | <input type="checkbox"/> Bone Density |
| <input type="checkbox"/> Breast Exam and Mammography (for women) | <input type="checkbox"/> Treadmill Test / EKG / ECHO |
| <input type="checkbox"/> Pap Smear / uterine / ovarian scan (for women) | <input type="checkbox"/> Estrogen levels |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Basal Temperature | <input type="checkbox"/> Free testosterone |
| <input type="checkbox"/> 3-5 hour Glucose Tolerance Test | <input type="checkbox"/> IgF-1 (a marker for human growth hormone) |
| <input type="checkbox"/> Fasting insulin | <input type="checkbox"/> DHEA-S |
| <input type="checkbox"/> Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL | <input type="checkbox"/> Cortisol |
| <input type="checkbox"/> Thyroid Studies (TSH, T4) | <input type="checkbox"/> SHBG (sex hormone binding globulin) |
| <input type="checkbox"/> Free T3 | |

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

- Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- Atherosclerosis (hardening of the arteries) _____
- High cholesterol or other form of abnormal lipids _____
- Heart attack or stroke _____
- Diabetes or any form of metabolic disease or obesity _____
- Cancer and list type(s) _____
- Osteoporosis or any form of bone disease _____
- Thyroid disease _____
- List any other diseases in your family _____

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

- | | |
|--|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Exhausted feelings that are not related to stress or amount of work or exercise.<input type="checkbox"/> Morning tiredness, even after a full night's sleep.<input type="checkbox"/> Depression that does not respond to antidepressants, diet, or exercise.<input type="checkbox"/> Unexplained anxiety and panic attacks.<input type="checkbox"/> Been told that I move as if in slow motion, and take too long to responds to questions.<input type="checkbox"/> A frequently low or hoarse voice (for a woman).<input type="checkbox"/> Mental sluggishness and have difficulty focusing.<input type="checkbox"/> Low sex drive and do not experience significant sexual arousal.<input type="checkbox"/> High cholesterol that has been unresponsive to diet or medications.<input type="checkbox"/> A tendency to feel cold even in warm weather.<input type="checkbox"/> Chronic aches and pains not due to accidents or exercise.<input type="checkbox"/> Carpal tunnel syndrome<input type="checkbox"/> Problems with allergies.<input type="checkbox"/> Difficulty losing weight and keeping it off. | <ul style="list-style-type: none"><input type="checkbox"/> Very dry skin.<input type="checkbox"/> I have acne or eczema.<input type="checkbox"/> Diabetes<input type="checkbox"/> Rheumatoid arthritis or other autoimmune condition.<input type="checkbox"/> Problem with my periods, including abnormal menstrual bleeding.<input type="checkbox"/> Anemia<input type="checkbox"/> Infertility or a history of frequent miscarriages.<input type="checkbox"/> Significant menopausal symptoms.<input type="checkbox"/> A tendency to have chronic constipation even with a high fiber diet.<input type="checkbox"/> Lots of hair falling out or brittle hair.<input type="checkbox"/> Vitiligo or other unusual changes in skin color.<input type="checkbox"/> Trembling of my hands or stumbling for no reason.<input type="checkbox"/> Have a family history of thyroid disorder<input type="checkbox"/> Have previously been diagnosed with a thyroid disorder |
|--|--|

FOR WOMEN ONLY: Confidential History

Name _____

Date _____

Age _____ Birth Date _____ Height _____ Weight _____ Date of last physical examination _____

What are your main health concerns? _____

MENSTRUAL & GYNECOLOGICAL SYMPTOM REVIEW

How old were you when you had your first period start? _____ Did you have any problems then?

How was your period in your twenties? _____ Thirties? _____

How is your period now (if you still are menstruating)? _____

Do you have any PMS symptoms? If yes, what are they?

Do you have menopausal symptoms?

Are you experiencing mood changes with menopause?

Name of your gynecologist _____ Date of last Pap smear _____

Have you had a mammogram? And when? _____ A bone density study (DXA scan)? _____

Number of children _____ Are you pregnant now? _____ Attempting pregnancy? _____

Do you have fibroids? _____ Size _____ Date of last sonogram _____

Ovarian cysts? _____ Breast cancer? _____

Is your cholesterol high? _____ Other cardiovascular risk factors _____

Do you have osteoporosis or osteopenia? _____ Do you have any urinary tract complaints? _____

Do you have any vaginal complaints? _____ How is your libido? _____

Other complaints? _____

MEDICATION REVIEW

What medications do you currently take? _____

Are you using prescription hormones? _____

Do you use any natural hormone preparations? _____

What nutritional supplements do you take? _____

Have you had any adverse reactions to medications? _____

PATIENT SIGNATURE: _____ **Date** _____

ANTI AGING SKIN CARE QUESTIONNAIRE

Do you have any concerns regarding the aging of your skin such as (check all that apply):

- Excessively dry skin
- Wrinkling skin
- Large Pores
- Red/Flushed skin
- Visible Blood Vessels
- Wrinkling around the eyes
- Deepening folds around the mouth
- Dark circles and puffiness around the eyes
- Adult acne

Are you currently using facial products that contain any of the following ingredients (Check all that apply):

- Vitamin C
- Retinol
- AHA
- Peptides
- Vitamin A
- Anti-oxidants

Have you ever had any of the following treatments (Check all that apply):

- Chemical Peels
- Skin Care Treatments
- Laser treatments
- Facial surgical procedures
- Dermabrasion

BHRT Consent

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____

Primary Doctor: _____

Natural or Bio-identical Hormone Replacement Therapy is the therapeutic use of hormones that are identical to the hormones made naturally by the body.

There are many different type but the ones used predominantly in our clinic include: testosterone, progesterone, estrone (E1), estradiol (E2), estriol (E3),

DHEA, androstenedione, cortisol, thyroid and melatonin. These hormones are typically used to treat symptoms of perimenopause, menopause, andropause (male menopause or low testosterone), thyroid dysfunction and adrenal fatigue (cortisol) although other symptoms may be treated as well.

Female patients:

The Women's Health Initiative Study (WHI) studied 16,608 postmenopausal women aged 50-79 years old with an intact uterus. The women received either Premarin

(0.625mg), Prempro (0.625/2.5mg), or placebo daily. These hormones were non human, non bioidentical hormones.

Users of Premarin and Prempro had :

- 41% more strokes (29 HRT VS 30 placebo in 10,000 person years)
- 29% more heart attacks (37 HRT VS 30 placebo in 10,000 person years)
- twice as many blood clots (34 VS 16 placebo in 10,000 person years)
- 26% more breast cancer (38 VS 30 placebo in 10,000 person years)
- 66% increase in Alzheimer's Dementia (45 HRT VS 22 in 10,000 person years)
- 37% less colorectal cancer (0.63 relative risk reduction)
- 33% fewer hip fractures (0.66 relative risk reduction)

The average age of the study participants was 63 years of age, and on average started hormone therapy 12 years after menopause. Synthetic hormones

(ex. Progestins), and bioidentical hormones such as progesterone have different effects on the body.

Bioidentical hormones can be used and metabolized as our body was designed to do, minimizing side effects. Bioidentical hormone dosages can be fine

tuned to your specific needs. Many European studies suggest that bioidentical hormones are safer than synthetic hormones. However, that doesn't mean

that bioidenticals are perfect. We also do not have any large scale, double blinded, placebo controlled trials on bioidenticals.

Relative Contraindications: personal family history of breast, ovarian, or endometrial cancer and a strong family history of breast or ovarian cancer. Close

collaboration with an oncologist may be needed in these situations. Unexplained vaginal bleeding may be another contraindication.

Precautions: BHRT does not increase heart disease risk if given at the proper dosage and ratio. Patients with previous deep vein thrombosis require careful

monitoring if they are taking oral estrogen. Women with known heart disease need routine evaluation and annual labs including cholesterol levels and EKG.

They will need to be followed up by their primary care physician for this condition.

Baseline hormone levels are ordered at your initial visit. You will then be given an individualized prescription of BHRT based on your symptoms and test

results. Symptom resolution is not immediate. It can take anywhere from 3-9 months until patients feel like they have the perfect fit. There are many different

preparations of BHRT (topical creams, sublingual troches, vaginal inserts, pills, and sublingual drops). Some women respond to one form better than another.

Saliva or serum / blood tests are measured every 2-4 months until stable. When stable, hormone levels are then monitored every 6-12 months depending on the situation.

Patient's bodies and lifestyles change and so do their hormonal needs. Hormones are usually measured via saliva, serum and or urine samples. Neurotransmitters are also evaluated in some situations and are done via a urine sample. You are required to have pap smears (as frequently as indicated), mammograms, and DEXA Scans (as indicated). It is required that you supply us with a copy of these results for our records. Hormones are generally not prescribed or renewed unless these records are up to date

Male patients:

Men on testosterone therapy are required to have their testosterone levels checked **at least** every three months for the first year and then at least twice per year thereafter. Levels may be checked more often depending on response to therapy. Male are also required to have digital rectal exam by primary physician and PSA levels prior to starting hormone and every 3 months while on treatment.

Bio-identical hormones are made at compounding pharmacies. BHRT is generally not reimbursed by insurance companies although there are exceptions. On request, the pharmacy will provide you with a form that you can fill out and submit to your insurance company for reimbursement. Many women generally use anywhere from one to five hormone preparations. Many times we can combine 2 or 3 hormones into one preparation once we have the correct dose for each of the individual hormones. This will help keep the cost down. We also require that you have a current primary care physician to manage all you other health needs.

I understand and agree to the above statements and all my questions have been answered to my satisfaction. I am consenting for bio-identical hormone treatment at Affinity Medspa and Wellness Center .

I understand that the treatment for bio-identical hormones at Affinity Wellness 4 Life by Dr. Michael P. Heim and Dominic Sorrentino PA-C, AAAHP is an out of network service.

Payment will be due at the time of initial service. Initial full 1st and 2nd visit is \$350.00 and f/u visits are \$175-200.00 every 3-4 months for 1st year then every 6 months thereafter. This does not include added costs for medications or supplements if needed.

Patient Signature _____ Date_____

Printed Name _____

Physician / Practitioner _____ Date_____



AFFINITY WELLNESS + LIFE

4335 Solutions Lane
Bradenton, FL 34211
941-739-7900

Financial Disclosure

The consultation fee includes the initial and 2nd visit, comprehensive medical history, physical exam (including blood pressure, heart rate, temperature, weight and body fat analysis), “one on one” assessment of laboratory results, bio-identical hormone replacement advisement and diet, supplementation and exercise advice.

Laboratory testing (including blood, salivary and urine testing) is NOT INCLUDED in the initial fee. NON-INSURED PATIENTS estimated fee for labs is \$200- \$500 depending on tests considered. INSURED PATIENTS WILL BE RESPONSIBLE FOR ANY FEES THAT YOUR INSURANCE COMPANY DOES NOT COVER AND IF UNSURE OF COVERAGE TO CONTACT APPROPRIATE CARRIER.

Bio-identical Hormone Replacement Therapy (BHRT) prescriptions and any other prescriptions and supplements are also not included in the initial fee and are the responsibility of the patient.

I understand that I am financially responsible for all laboratory fees or fees not covered by my insurance company. I also understand that I am also financially responsible for all prescriptions and supplements. (Initial) _____

All sales are FINAL. No transfers, exchanges or misuse of any product or services rendered other than the original patient of whom they are intended for. (Initial) _____

Patient Signature

Date

Witness Signature

Date