VIVANT MEDICAL
WELLNESS AND AESTHETICS

6214 Memorial Hwy Ste B Tampa, Fl 33615
(800) 574-9491 - www.vivantmed.com

PERSONAL DATA		
Name:	Date:	Social Security #:
Address:	City State:	Zip:
Home Phone:	Work Phone/Cell Phone:	Date of Birth:
Employer:	Emergency Contact:	Phone:
Email:	Marital Status: ☐ Married ☐ Single	

PRIMARY CARE PHYSICIAN		
Name:	Phone/Fax Number	
Address:	City State:	Zip:
Primary Name:	Phone/Fax Number	

PRESENT SYMPTOMS

PAST MEDICAL HISTORY	
Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.	
Date	**Medical Diagnosis, Illness, Accident**

PAST SURGICAL HISTORY	
Date	**Surgery**

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MEDICATIONS: Please list ALL prescription medications.
Include ALL over the counter medications, supplements, and vitamins.

Name of Medication	Dosage	Dosing Schedule

ALLERGIES: Are you allergic to any MEDICATIONS (Prescription or OTC)

FAMILY HISTORY

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

SOCIAL HISTORY

Please remember that this information is strictly confidential and will be used only to address your symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (bear, wine, spirits etc.) do you have in an average week?

_____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

If yes, what substance(s) and how often? _____

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GYNECOLOGICAL HISTORY	
Date of last PAP smear? _____	Physician who performed? _____
Physician's Phone Number: _____	
Date of last mammogram? _____	Facility where performed: _____
Facility Phone Number: _____	

	Yes	No
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have _____	☐	☐
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have _____	☐	☐
Have you ever had a breast biopsy?	☐	☐
Have you ever had a cervical biopsy?	☐	☐
Have you notices breast skin or nipple changes?	☐	☐
Have you noticed any lumps in your breast?	☐	☐
Are you using a birth control method? If yes, what kind? _____	☐	☐
Are you still having menstrual periods? If yes, when was the first day of your last period? _____	☐	☐
Please describe any problems you have with your periods: _____		
Periods are (were): ☐ Regular ☐ Irregular ☐ Painful ☐ Crampy ☐ Heavy ☐ Light ☐ Other: _____		
Age periods began: _____ # days of bleeding _____ Cycle length (days) _____		
If you are no longer having periods, at what age did your periods stop? _____		
If your periods stopped less than one year ago, how many months ago was your last period? _____		
Did your periods stop because you had a hysterectomy?	☐ Yes	☐ No
• If yes, what was the reason for the surgery? _____		
• Were the ovaries removed at the same time?	☐ Yes	☐ No ☐ Not Sure

Do you have history of any of the following cancers?

☐ Vulva	☐ Ovary	☐ Uterus
☐ Fallopian Tube	☐ Vagina	☐ Breast
☐ Cervix	☐ Colon	☐ Other: _____

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HORMONE THERAPY HISTORY				
Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of Treatment:				
Hormone	**Dose**	**Reason**	**Start Date**	**Stop Date**

ESTROGENS		
Check which of these symptoms are troublesome and have persisted over time.		
Estrogen Deficiency	**Estrogen Excess / Progesterone Deficiency**	
☐ Hot Flashes	☐ Mood Swings (PMS)	☐ Uterine Fibroids
☐ Night Sweats	☐ Cystic Ovaries	☐ Uterine Fibroids
☐ Vaginal Dryness	☐ Tender Breasts	☐ Weight Gain – Hip Area
☐ Foggy Thinking	☐ Heavy Menses	☐ Bleeding Changes
☐ Memory Lapses	☐ Water Retention	☐ Elevated Triglycerides
☐ Urinary Incontinence	☐ Sugar Craving	☐ Breast Cancer
☐ Tearful	☐ Nervousness	☐ Low Libido
☐ Depressed	☐ Irritable	
☐ Sleep Disturbances	☐ Anxious	
☐ Heart Palpitations / Arrhythmia	☐ Fibrocystic Breast	
☐ Bone Loss	☐ Headaches	
☐ Headaches	☐ Cold Body Temperature	

ANDROGEN		
Check which of these symptoms are troublesome and have persisted over time.		
Androgen Excess	**Androgen Deficiency**	
☐ Increased Facial Hair	☐ Low Libido	☐ Heart Palpitations / Arrhythmia
☐ Increased Body Hair	☐ Vaginal Dryness	☐ Headaches
☐ Acne	☐ Fatigue	☐ Fibromyalgia
☐ Oily Skin	☐ Aches / Pains	☐ Irritable
☐ Nervous	☐ Memory Lapses	☐ Thinning Skin
☐ Irritable	☐ Foggy Thinking	☐ Bone Loss
☐ Anxious	☐ Urinary Incontinence	
☐ Breast Cancer	☐ Depressed	
☐ Ovarian Cysts	☐ Anxious	
☐ Elevated Triglycerides	☐ Sleep Disturbances	
☐ Sleep Disturbances	☐ Apathy / Decreased Passion for Life	
☐ Prostrate Problems	☐ Decreased Muscle Mass	

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ADRENALS		
Check which of these symptoms are troublesome and have persisted over time.		
Cortisol Excess		**Cortisol Deficiency**
☐ Sleep Disturbances	☐ Heart Palpitation / Arrhythmia	☐ Exhaustion / Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain – Waist	☐ Nervousness	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Apathy/Decreased Passion for Life
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches / Pains
☐ Memory Lapses		☐ Cold Body Temperature

THYROID		
Check which these symptoms are troublesome and have persisted over time.		
Thyroid Excess	**Thyroid Deficiency**	
☐ Heat Intolerance	☐ Cold Intolerance	☐ Aches / Pains
☐ Irritable	☐ Constipation	☐ Hair Loss
☐ Heart Palpitations/Arrhythmia	☐ Fatigued / Weakness	☐ Muscle Weakness
☐ Weight Loss	☐ Unexplained Weight Gain	☐ Muscle Cramps
☐ Tremors/Shakiness	☐ Inability to Lose Weight	
☐ Diarrhea	☐ Stress	
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature	
☐ Insomnia	☐ Coarse Dry Skin	
☐ Difficulty Conceiving / Infertility	☐ Lack of Motivation	
	☐ Voice has become hoarse	

SYSTEM REVIEW – Check the appropriate box for each question.			
Constitutional / ID / Oncology	**Yes**	**No**	**Not Sure**
Have you had unexplained wight loss?	☐	☐	☐
Do you have fever and chills?	☐	☐	☐
Do you have night sweats?	☐	☐	☐
Do you notice swollen lymph nodes?	☐	☐	☐
Have you ever tested positive for HIV?	☐	☐	☐
Have you ever had a sexually transmitted disease?	☐	☐	☐

Respiratory			
Do you have a persistent cough?	☐	☐	☐
Do you have recurrent sinus infections?	☐	☐	☐
Do you have excessive daytime sleepiness?	☐	☐	☐
Do you snore?	☐	☐	☐
Have you ever been diagnosed with asthma or emphysema?	☐	☐	☐

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SYSTEM REVIEW – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?	☐	☐	☐
Do you have palpitations?	☐	☐	☐
Do you have shortness of breath?	☐	☐	☐
Do you have swelling in your legs?	☐	☐	☐
Do you have leg pain while walking?	☐	☐	☐
Vascular disease or artery blockages/aneurysms?	☐	☐	☐
Have you been diagnosed with any heart condition?	☐	☐	☐
Have you ever been diagnosed with a blood clot?	☐	☐	☐
Gastrointestinal			
Do you have problems swallowing food?	☐	☐	☐
Do you have nausea or vomiting?	☐	☐	☐
Do you have diarrhea?	☐	☐	☐
Do you have blood in you stool?	☐	☐	☐
Do you have abdominal pain or swelling?	☐	☐	☐
Have you ever been diagnosed with hepatitis or liver disease?	☐	☐	☐
Endocrine			
Do you urinate frequently or in larger amounts than usual?	☐	☐	☐
Do you have greater than normal urge to eat?	☐	☐	☐
Do you have elevated bool sugar? Diabetes?	☐	☐	☐
Are you excessively thirsty?	☐	☐	☐
Do you have facial hair?	☐	☐	☐
Do you have acne?	☐	☐	☐
Have you ever been diagnosed with a thyroid problem?	☐	☐	☐
Neurological			
Do you have muscle weakness?	☐	☐	☐
Have you ever had a seizure?	☐	☐	☐
Have you ever fainted?	☐	☐	☐
Have you experienced double vision or blind spots?	☐	☐	☐
Have you ever been diagnosed with a stroke?	☐	☐	☐
Urologic / Renal			
Do you have burning when you urinate?	☐	☐	☐
Do you have urgency when you urinate?	☐	☐	☐
Do you urinate more frequently than others?	☐	☐	☐
Do you leak urine when laughing or coughing?	☐	☐	☐
Have you ever had any kidney problems?	☐	☐	☐

Physician Notes:

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Disclosure / Liability Waiver
Vivant Medical – Bio-Identical Hormone Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life-threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from VIP Aesthetics, LLC. its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

Signature of Patient:	Date:
Print Name:	Date:

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, mammogram, prostate examination, and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

Signature of Patient:	Date:
Print Name:	Date: