SUMMIT MEDICAL CARE CENTER, L.L.C.
ABOVE AND BEYOND WELLNESS

bioTE MEDICAL

Living Well
Nutrition Solutions for Life

Female Patient Questionnaire & History

Name:_____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ Weight: _____ Height: _____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip: _____

Best Contact Number:_____ Alternate #: _____

E-Mail Address:_____

In Case of Emergency Contact:_____ Relationship: _____

Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Number of children: _____

Please list your TOP 3 unwanted symptoms/health concerns:

1._____

2._____

3._____

Please circle the services (as many as apply) you are interested in hearing about at our clinic:

Weight Loss Nutrition Hormone Balance/BioTE Pain/Inflammation Reduction

Stress Support Digestive Support Lab Work / Food Sensitivity Testing Red Light Therapy

Allergy Elimination with Laser Neurofeedback Chiropractic Massage therapy

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Health Intake

Nutritional/Vitamin Supplements: _____

_____

_____

Digestion/Elimination: Check any: ( ) I have a normal bowel movement daily ( ) I have two or more BMs daily
( ) I don't eliminate every day ( ) I have less than 2 BMs weekly ( ) I eliminate daily, but loose/watery
( ) I use laxatives ( ) I have heartburn / acid reflux / GERD ( ) I experience gas /discomfort/bloating
( ) I have/had hemorrhoids

Weight/Body Composition: Check one: ( ) I am content with my body and weight currently
( ) I want to lose ____ lbs. ( ) I want to gain ____ lbs. ( ) I am using or have used methods to control my weight

Physical Activity: ___ Low/Sedentary (spend more time sitting/driving than walking/exercising)
___ Moderate (average mix of exercise/activity) ___ Active (work out 5-7 days weekly for 30 min. or more)
Exercise routine if applicable _____

Daily Habits: Check any/all that apply:
( ) I eat only when I'm hungry ( ) I eat 3-5 small meals daily ( ) I skip meals unintentionally
( ) I over eat unconsciously ( ) I don't really think about eating; it just happens ( ) No matter how much I eat I am never full ( ) I eat foods I know don't agree with me/knowing I'll feel uncomfortable after eating them
( ) I eat when I'm sad or stressed or anxious ( ) I eat secretly ( ) I want to improve my eating habits
( ) I drink regular soda ____ daily ____ weekly ____ rarely ____ never
( ) I drink diet soda ____ daily ____ weekly ____ rarely ____ never
( ) I drink energy drinks (i.e., red bull, celsius, monster) ___ daily ___ weekly ___ rarely ___ never
( ) I drink coffee ___ cups daily ( ) I don't drink coffee ( ) I smoke or use nicotine ___ yes ___ no
( ) I drink alcoholic beverages ___ number of drinks weekly ___ I only drink socially/rarely
( ) I choose not to drink alcohol ( ) I am a recovering alcoholic (sober since ____)
( ) I drink water: ____ less than 3 cups (24 oz) daily ____ 3—7 cups daily ____ 8 cups + daily
( ) I use THC ___ yes ___ no If yes, what form and how much (daily, weekly…) _____
( ) I drink or use dairy (milk, skim milk, yogurt, cheese, butter, creams, ice cream) ____ yes ____no
( ) I crave: ____salty foods ____ sweets ____ bread/pasta/beer ____caffeine ____ alcohol ____ dairy

Known or Suspected Allergies or Food Sensitivities: _____
( ) I have been diagnosed with or suspect yeast overgrowth/candida ( ) I battle sinus/allergy or asthma

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes, please explain: _____

Medications with dosing: _____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____ Infertility/Miscarriage _____
I have completed my family ___ yes ____no

Other Pertinent Information: _____

Preventative Medical Care:

( ) Medical/GYN exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

( ) Breast cancer.
( ) Uterine cancer.
( ) Ovarian cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy removal of ovaries.

Birth Control Method:

( ) Menopause
( ) Hysterectomy
( ) Tubal ligation
( ) IUD
( ) Birth control pills
( ) Vasectomy
( ) Other: _____

Medical Illnesses:

( ) Polycystic Ovary Syndrome (PCOS)
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Acid Reflux
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or pulmonary embolism
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Kidney Stones
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Crohn's/Colitis
( ) Cancer (type):
Year: _____

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Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Bladder/bowel incontinence				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Eczema, Psoriasis or Acne (circle any)				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Female Testosterone and/or Estradiol Pellet Insertion and/or Nurse Practitioner Consultation Consent Form

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.
Bio-identical hormone pellets are plant derived and are FDA monitored. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets. Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

- o Abstinence
- o IUD
- o Other
- o Birth control pill
- o Menopause
- o Hysterectomy
- o Tubal ligation

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are like those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below**:
Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors(endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.
BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.
I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.
I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____	_____	_____
Print Name	**Signature**	**Today's Date**

Informed Consent for Nutritional Services and/or Purchases of Goods/Services

Living Well, LLC, Amy Richardson, Certified Nutrition Therapist (CNT) is not a medical professional. I understand that Living Well, LLC, Amy Richardson, (CNT) does not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent as so doing. The services of a Nutrition Professional cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not, to assist you in your care is your right and Living Well, LLC, Amy Richardson, (CNT) assumes no responsibility for your decision in this matter. By signing below, you are stating that you have informed Living Well of all your known physical conditions, medical conditions, and medications, and will keep them informed of any changes.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Living Well, LLC, Amy Richardson, (CNT) as I so choose. I hereby release Living Well, LLC, Amy Richardson, (CNT) from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Living Well, LLC, Amy Richardson, (CNT) and participate in a professional relationship with them pursuant to the statements herein.

Client's Name (print) Client's Signature Date

If Minor, Client's Representative (print) Signature of Client's Rep. Relation to Client Date