Medical Release Authorization

"I hereby authorize my Physician to furnish an agent of Anderson Compounding Pharmacy any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Anderson Compounding Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that an Anderson Compounding Pharmacy employee will not release this information unless authorized by me in writing. This authority shall continue until revoked by me in writing."

Physician Information

Physician Name (to send test results to):____

Office Address:____

City, State, Zip:____

Office Phone:____

PATIENT INFORMATION

Patient Name: ____

Address: ____

City, State, Zip:____

Home Phone#: ___________________Work Phone#___________________ Cell Phone#:___________________

Email Address: ____

Date of Birth:____________________ Social Security # (used only for patient filing purposes):________________________

Consult Date: _____________________

How did you hear about us?

☐ TV commercial ☐ Seminar ☐ Newspaper ☐ Radio ☐ Already an existing customer

☐ Doctor, friend or family member--if so, please provide their name: ___________________________________

Patient Signature:____Date:____________________

*Please include a copy of your prescription insurance coverage information, or have us make a copy when you arrive

OFFICE FEE SCHEDULE

Women's Health Collaborative Care Program

New Patient Visits

Initial BHRT & Nutritional Consultation (~ 1 hour)	$150.00
BHRT Follow-Up Visit for Discussion and Review of Lab Work (~15 minutes)	$30.00

BHRT ***Follow-Up*** Appointments

15 minute visit (1-15 minutes)	$30.00
30 minute visit (16-30 minutes)	$60.00
45 minute visit (31-45 minutes)	$90.00

**If your visit extends past your appointment time you will be billed accordingly…

Appointment *Cancellation Fee* (when less than 24 hours notice is given) = full price corresponding to the allotted appointment time

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Phone Consultations:

Initial BHRT Clinical Consultations as well as follow up visits may be scheduled as a "phone consult" to accommodate those who may be out of town or unable to travel to our office.

The Clinical Pharmacist bills for all phone calls made to patients. Please be sure to allow our staff to answer your questions first before requesting to speak with the clinical pharmacist to avoid needless fees. If our staff is unable to help you, an office visit or phone consult will be scheduled.

We also require a credit card to keep on file for patients for any mailed prescriptions orders &/or laboratory test kits and for appointment cancellation fees. All fees are due at the time of service.

By signing below, you acknowledge that you have read this document and agree to abide by our office policies.

Patient's Name (please print)

Patient's Signature

____

Credit Card Information Authorization

I, (Please print name) ______________________________, authorize Anderson Compounding Pharmacy Women's Health Clinical Services to charge my credit card for the following reasons: *mailed orders/prescriptions, phone consultations, and cancellation fees.*

Women's Health Clinical Services
Division of ANDERSON COMPOUNDING PHARMACY
310 Bluff City Highway
Bristol, TN 37620
423.764.4136 opt. #3

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under that Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my pharmacy provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my pharmacy provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ____Date: ___________

Address: ____Phone # ____________________

____

Signature: ____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

PATIENT INFORMATION AND HEALTH SUMMARY

NAME____

Date of Birth____/____/____ Age__________ Height__________ Weight__________

Relationship status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Engaged ☐In a Relationship

Do you drink alcohol? ☐Yes ☐No
If yes, how much and how often____
Do you smoke? ☐Yes ☐No
If yes, how many packs per day? ____
Do you exercise? ☐Yes ☐No
If yes, what type and how often? ____
Do you consume caffeine? ☐Yes ☐No
If yes, what type and how often? ____

Are you currently on any prescription medications/supplements? ☐Yes ☐No
If yes, please list the medications and/or supplements on the lines below:

Medications:	Supplements:
1________________________	1________________________
2________________________	2________________________
3________________________	3________________________
4________________________	4________________________
5________________________	5________________________
6________________________	6________________________
7________________________	7________________________
8________________________	8________________________
9________________________	9________________________
10_______________________	10_______________________

MEDICATION ALLERGIES (please check all that apply):
☐ None known ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Codeine

Please list any other MEDICATION and/or FOOD allergies you have: -
____
____

Are you chemically and/or environmentally sensitive? ☐Yes ☐No

CONSULT DATE: ______ / ______ / ________

Bio-Identical Hormone Replacement Therapy Consultation/Assessment Information

MEDICAL HISTORY

Current Medical Conditions (please check all that apply)	
☐ Asthma	☐ Arthritis
☐ Cancer (type:____________________)	☐ Blood Clots (DVT, pulmonary embolism)
☐ Chronic Fatigue Syndrome	☐ Clotting Disorder
☐ Depression	☐ Eating Disorder
☐ Diabetes (type: ________________)	☐ Fibromyalgia
☐ Epilepsy	☐ Gallbladder Disease
☐ Fractures	☐ High Cholesterol
☐ Headaches/Migraines	☐ Kidney Disorder
☐ Heart Condition (type:___________)	☐ Thyroid Disorder
☐ High Blood Pressure	☐ Ulcers
☐ Liver Disorder	☐ Bipolar Disorder
☐ Osteoporosis/Osteopenia	☐ Other: ________________________
Family History (please check all that apply)	
☐ Cancer: type-____________________ who?______________________	☐ Heart Disease: who? ______________
☐ Diabetes: type-_________________ who? ____________________	☐ Alzheimer's Disease: who? ________
	☐ Osteoporosis: who? _______________

In your own words, please tell us briefly about your past medical history.

____

____

____

____

____

____

____

What would you like to gain from this consultation/ Why are you seeking hormone related counseling?

____

____

____

____

____

____

NAME: _______________________________________CONSULT DATE: ______ / ______ / ________

Menstrual History

1. Describe your menstrual periods presently (check all that apply):

   - ☐ Regular
   - ☐ Irregular
   - ☐ Clotty
   - ☐ Light
   - ☐ Heavy
   - ☐ Midcycle spotting
   - ☐ Sporadic
   - ☐ No periods
   - ☐ Brown Blood
   - ☐ Bright Red Blood

2. How would you describe the cramping/pain/discomfort at the time of your period?
   ____

3. What have you found that alleviates the discomfort?
   ____

4. Have you ever skipped periods all together? ☐ Yes ☐ No
   If yes, please explain:
   ____

5. First day of last period? ________________________ How long is your cycle? __________ days

6. Do typically have any bleeding between periods? ☐ Yes ☐ No
   When? ____

7. When was your last test:

   - Pap Smear __________________
   - Cholesterol __________________
   - Mammogram ________________
   - Bone density __________________
   - Hormone Panel ________________
   - Thyroid Panel ________________

8. Have you ever taken hormones (synthetic or natural) before? ☐ Yes ☐ No

   If yes, please list the HORMONE MEDICATION(s) you have used on the lines below:

	Drug Name	Strength	When Used	Side Effects	Benefits
1					
2					
3					
4					
5					

9. If you discontinued the use of any hormones therapies in the past, please briefly explain why.
   ____
   ____

10. Have you tried any alternative therapies or taken any herbal products to help with your symptoms?
    ☐ Yes ☐ No If yes, please list them here:
    ____
    ____
    ____

NAME: ____ CONSULT DATE: ______ / ______ / ________

OBSTETRICAL HISTORY

1) Are you sexually active? □ Yes □ No

2) Are you satisfied your current level of sexual activity? □ Yes □ No
   If no, please mark all that apply:

   __I rarely feel like having sex __Only at certain times during the month. If so, when? ________________

   __Problems with my relationship affect my desire __I am too tired __I cannot achieve orgasm

   __I can achieve orgasm but it takes longer and/or is not as intense

   __My partner struggles with libido __Other____

3) Are you actively trying to get pregnant? □ Yes □ No
   Current method of birth control? ___________________________ How long? _________
   Past birth control and any related problems? ___________________________________

   Have you ever had children? □ Yes □ No Current Age(s) _____________________

   Number of pregnancies___ deliveries___ miscarriages ___ terminations ___
   Are you nursing? □ Yes □ No

   Additional notes regarding pregnancy history: ____
   ____
   ____

4) Do you have stretch marks/scar(s) and would like to minimize their appearance? ? □ Yes □ No

5) Are you currently undergoing infertility treatment?
   If yes, please explain which treatments have been successful/unsuccessful.
   ____
   ____
   ____

GYNECOLOGICAL HISTORY

1) Have you ever had a hysterectomy? □ Yes □ No
   If yes, when & why?
   ____
   ____

2) Have you had any part of or your whole ovary removed? □ Yes □ No
   If yes, when & why?
   ____
   ____

3) Have you had a tubal ligation (tubes tied)? □ Yes □ No
   If yes, when? _____________________________________

4) Have you ever had an abnormal pap? □ Yes □ No
   If yes, what was the abnormality and how was it treated? _______________________________________

NAME: ____________________________________CONSULT DATE: ______ / ______ / ________

5) Please check any of the following conditions you currently have:

- ▫ HSV (vaginal herpes) ▫ Cervical Cancer ▫ Uterine fibroids
- ▫ HPV (vaginal warts) ▫ Cervical dysplasia ▫ Breast fibroids
- ▫ Ovarian cysts ▫ Pelvic infections ▫ Infertility
- ▫ Increased facial and/or body hair growth Other:____

6) Do you have redness of the skin/face that you would like to minimize? Yes No
Do you know the cause? If so please explain____

7) Do you have callused, rough or scaly skin? Yes No If yes, where? ___________________

Additional information pertinent to your overall health and well-being:

- What is the average time interval between meals? (in hours) ________________________________
- What time do you typically have your first meal of the day? _________________________________
- Do you skip meals? ▫ Yes ▫ No If so, which meals? ______________________
- What is your occupation? ________________________how many hours per week?____________
- Do you enjoy your work? ▫ Yes ▫ No ▫ N/A
- What time do you typically: get in bed?______ fall asleep?_______ wake up?___________
- Do you tend to feel well rested when you wake up? ▫ Yes ▫ No
- How often do you have a bowel movement? ____
- Please indicate types of fat you regularly consume/cook with: __butter __margarine __canola oil __olive oil __coconut oil __grapeseed oil __vegetable oil other____________
- How often do you consume diet drinks? ____
- How often do you use a sugar substitute? Which type? __________________________________
- How often do you eat out? ____
- What are the top 10 foods present in your diet?

____

____

NAME: ____________________________________CONSULT DATE: _______ / _______ / _________

Hormone Imbalance/Deficiency Symptoms Rating Scale

Which of the following symptoms apply to you at this time? Please circle the appropriate # for each symptom. For symptoms that do not apply, please mark 'none'.

Symptoms:

	none	mild	moderate	severe	very severe
Score =	0	1	2	3	4
1. Hot flashes (episodes of sweating)……………………………..	0	1	2	3	4
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)…………….	0	1	2	3	4
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early)………..	0	1	2	3	4
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)……………….	0	1	2	3	4
5. Irritability (feeling nervous, inner tension, feeling aggressive)……………………………………………………….	0	1	2	3	4
6. Anxiety (inner restlessness, feeling panicky)………………	0	1	2	3	4
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)…………………………………………	0	1	2	3	4
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)………………………………….	0	1	2	3	4
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)………	0	1	2	3	4
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)………..	0	1	2	3	4
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints) ……………………………………………….	0	1	2	3	4
12. Migraine Headaches…………………………………………………….	0	1	2	3	4
13. Weight Gain…………………………………………………………………	0	1	2	3	4

NAME: ____ CONSULT DATE: ______ / ______ / ________