BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

FEMALE PATIENT INFORMATION FORM

Last Name_____ First Name _____Middle_____

Date of Birth _____/_____/_____ Age_____ Sex: M / F Marital Status: M S D W

Email: _____ Phone: Home: _____ Cell: _____

Home Address: _____

City_____ State _____ Zip_____

PREFERRED METHOD OF CONTACT? (please circle) Home Phone Cell Phone Email

Employer_____Occupation_____

REASON FOR VISIT / MAIN CONCERN_____

Primary Care Physician_____ Date of Last Physical_____

PRESCRIPTION MEDICATIONS *(PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)*

Medication	**Dose and Frequency**
1.	
2.	
3.	
4.	
5.	

NON PRESCRIPTION MEDICATIONS *(LIST OVER THE COUNTER, HERBAL, AND VITAMINS)*

1.	3.	5.
2.	4.	6.

DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS? NO_____YES_____

MED:_____ REACTION:_____

MED:_____ REACTION:_____

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PLEASE LIST ANY ALLERGIES OR REACTIONS TO FOODS OR ENVIRONMENTAL SUBSTANCES?

_____

Health History For Women

Lifestyle information: Answer the following questions with Yes or No and explain if necessary.

Are you concerned about aging? ☐Yes ☐No, Do you have a specific concern?_____

Are you concerned about appearance? ☐Yes ☐No, Have you had Aesthetic treatments?_____

Are you concerned about memory loss? ☐Yes ☐No

Are you under a great deal of stress, now or recently? ☐Yes ☐No

Do you practice any form of stress reduction (Meditation, yoga, tai chi)? ☐Yes ☐No, _____

Are you concerned about your weight? ☐Yes ☐No

Current Symptoms: Please mark any of the following that may apply.

☐Decreased or absent sex drive (libido)
☐Fatigue and lack of energy
☐ Irregular Periods
☐Change in mood, anxiety and/or depression
☐Insomnia
☐Declining mental ability and memory
☐Feeling of hopelessness or no motivation
☐New headaches
☐Diminished strength and exercise tolerance
☐Muscle shrinkage
☐Joint aches or new onset of arthritic symptoms
☐Dry eyes
☐Poor balance and coordination
☐Weight gain, belly fat

☐Hot flashes and night sweats
☐Dry vagina or painful intercourse
☐Dry and wrinkled skin
☐Height has decreased, osteoporosis or osteopenia
☐Bladder spasms
☐Bladder infections
☐PMS
☐Hair loss
☐Cold all the time
☐Swelling
☐Constipation
☐Hair falling out or breaking off (brittle)
☐ Mental sluggishness and have difficulty focusing
☐ New or increased cellulite

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Medical History: Please mark any of the following that may apply.

☐Any form of Hepatitis or HIV- Type_____

☐Breast cancer

☐Uterine cancer

☐Colon cancer

☐Ovarian cancer

☐Other cancer:_____

☐Blood clot or clotting disorder

☐Heart attack

☐Stroke

☐Vascular Disease

☐High blood pressure

☐High cholesterol

☐Heart arrhythmia

☐Multiple sclerosis

☐Tuberculosis

☐Glaucoma

☐ADD/ADHD

☐Depression/anxiety

☐Manic depression

☐Schizophrenia

☐Kidney disease

☐GI Upset/GERD

☐Glaucoma

☐Psychological/psychiatric illness _____

☐Restless leg

☐Sleep apnea

☐Narcolepsy

☐Arthritis

☐Rheumatoid arthritis

☐Osteopenia or osteoporosis

☐Fibromyalgia

☐Lupus or autoimmune disease

☐ Adrenal fatigue

☐Chronic fatigue

☐ Seizures

☐Emphysema (COPD)

☐Diabetes type I

☐Diabetes type II

☐Hypoglycemia

☐Insulin resistance

☐Thyroid disease Hypo_____ Hyper_____

☐Addisons disease or cushings disease

☐Liver disease

☐Irritable Bowel Type Symptoms

☐Other _____

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Surgical History: Please list all surgeries and approximate dates.

_____

_____

_____

_____

Social History: Please mark any of the following that may apply.

☐I am menopausal ☐I have completed my family

☐I have permanent birth control ☐I am married

☐I have a partner ☐I am in a committed relationship

Habits: Please mark any of the following that may apply.

Smoking: **Drinking:**

☐I have never smoked

☐I smoke cigarettes: packs per day:_____ ☐I drink more than 12 drinks per week

☐I smoked previously. Quit Date: _____ ☐ I drink less than 12 drinks per week

☐ I use vapor cigarettes ☐ I am a recovering alcoholic

Caffeine:

☐I drink caffeinated beverages. _____servings/day. Type: _____

Other Drugs:

☐I use or have used marijuana in the last year

☐I use cocaine or Heroin or have a history with the use of them.

☐ I use other drugs: _____

Exercise History: Please mark any of the following that may apply

☐I don't exercise ☐Normal daily activity is what I consider exercise

☐I have a very physical job so I don't exercise ☐I am a long distance runner

☐I exercise every day for _____ minutes ☐I lift weights _____ times a week

☐I exercise more than 3 times/week > 50min. ☐Other:_____

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Dieting: Please mark any of the following that may apply

Do you overeat? ☐Yes ☐No, How is your appetite?_____

Do you ever have any reactions to food? ☐Yes ☐No, _____

Do you crave sweets? ☐Yes ☐No, Or any other food cravings?_____

Please mark which of the following describes your typical daily diet:

☐I eat anything I want ☐I limit carbohydrates

☐I don't eat much but gain weight anyway ☐I eat a low fat diet

☐I have gained weight in my belly ☐Atkins

☐I eat a balanced diet, 3 times a day ☐Vegan/vegetarian

☐I eat 6 small meals a day ☐Special diet or restrictions _____

☐Other _____

Preventive Medical Care: Please mark any of the following that may apply.

☐Physical Exam Date_____ ☐Mammogram Date_____

☐Clinical Breast Exam Date _____ ☐Pap Test Date _____

☐Bone density (over 50) Date_____ ☐Pelvic ultrasound (still have uterus) Date_____

☐Labs Date _____ ☐Colonoscopy Date _____ Polyps? ☐Yes ☐No

☐Last Menstrual Period: _____

Family History (mother/father/sister/brother): Please mark any of the following that may apply.

☐Heart disease ☐Alzheimer's/dementia of any type

☐Colon cancer ☐Prostate cancer

☐Breast cancer ☐Blood clots

☐Uterine cancer ☐Other Bleeding Disorders

☐Other cancer:_____ ☐Rheumatoid arthritis/Lupus/Autoimmune Disease

☐Stroke ☐Thyroid disease- high or low

☐Arrhythmia ☐Osteoporosis

☐Diabetes ☐Hemochromatosis

☐Any other pertinent family history information _____

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Anti-Aging/Hormone Consultation Patients: Please mark any of the following that may apply.

Sexual History (present): Please mark any of the following that may apply.

☐I have a new sex partner in the last 3 years ☐My sex life is good

☐I have the ability to have an orgasm ☐I have never had an orgasm

☐I had orgasms before I was 40, but not now ☐I had sexual fantasies in the past

☐I still have sexual fantasies ☐My sex life has gotten worse after 40

☐My sex life is better than before 40

Hormone Replacement I have used in the past: Please mark any of the following that may apply.

☐Oral pills synthetic (Ogen, Premarin, Estrace, Etc.)

☐Patches ☐Vaginal ring

☐Pellets ☐Creams/gels applied on the skin or in the vagina

☐Sublingual/buccal tablets (dissolve in mouth) ☐Other_____

I UNDERSTAND THAT DR. OHMS DOES NOT DO PAP/PELVIC EXAMS OR PROSTATE EXAMS ON ANY PATIENTS. PLEASE DO THESE REGULAR TESTS WITH YOUR GYNECOLOGIST, UROLOGIST , etc. I AGREE TO HAVE THESE AS WELL AS MAMMOGRAMS, CLINICAL BREAST EXAMS, AND ANY OTHER ROUTINE HEALTH MAINTENANCE/PREVENTIVE TESTING INDICATED IN MY SPECIFIC CASE DONE PER CLINICAL GUIDELINES. I UNDERSTAND THAT DR. OHMS WILL NOT BE ABLE TO CONTINUE CERTAIN TREATMENTS (ESPECIALLY HORMONE REPLACEMENT), IF I AM NOT UP TO DATE WITH MY ROUTINE PREVENTIVE CARE TESTS.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY MEDICAL CARE AND I, THEREFORE CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM DR. OHMS OF ANY CHANGES OR UPDATES.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SUBMIT CLAIMS TO INSURANCE FOR POSSIBLE REIMBURSEMENT. I UNDERSTAND THAT BALANCED REJUVENATION HAS NO CONTRACTS WITH MEDICARE AND/OR ANY OTHER INSURANCE COMPANY. THEREFORE, BALANCED REJUVENATION IS NOT OBLIGATED TO PRE-CERTIFY TREATMENT, PROCESS PRIOR AUTHORIZATIONS OR ANSWER LETTERS OF APPEAL.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

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HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

*Please indicate the preferred method of contact (you may select more than one if you have no preference)?

_____ cell phone _____ home phone _____ email

*(at times, we may need to send appointment reminders, notices of office closures, whole practice updates, etc. If there is a reason that you ABSOLUTELY do NOT want us to use a certain method of communication, please state it here and/or tell us verbally at this appointment. _____

Is it ok to leave a message that includes:

Practice name and phone number only? _____Yes _____No

Detailed or specific message? _____Yes _____No

Would you like to authorize someone else to schedule, confirm, or change appointments? _____Yes _____No

If so, please provide: Name _____ Phone _____

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name _____

HOW DID YOU HEAR ABOUT US?

___ Friend or Family Member (Name) _____

___ Website: ___ *BalancedRejuvenationMed.com*

___ Internet Search (Google / Yahoo / Other) _____

___ Newspaper/Newsletter or Mailer _____

___ An Article or Advertisement in _____

___ Other _____

Deanna Ohms, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on her website www.balancedrejuvenationmed.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

Name:_____ Signature:_____ _____ Date:_____