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: _____ Cell Phone: _____

Home Address: _____

City_____ State _____ Zip_____

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. | |
| Additional: | |

**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 memory loss? ☐Yes ☐No

Are you under a great deal of stress, now or recently? ☐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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**Personal 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:**

☐I have never smoked

☐I smoke cigarettes: packs per day:_____

☐I smoked previously. Quit Date: _____

☐ I use vapor cigarettes

**Drinking:**

☐ I don't drink , but not due to problem with alcohol

☐I drink more than 12 drinks per week

☐ I drink less than 12 drinks per week

☐ 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

☐I exercise _____ days /week, for _____ minutes/day

☐Type of exercise that you do regularly: _____

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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

☐Vegan/vegetarian ☐I eat a balanced diet, 3 times 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 (Grandparents/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.

☐My sex life is good

☐I have the ability to have an orgasm

☐I have never had an orgasm

☐Sex is painful

☐I would like to discuss issues with my sex life

**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 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 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

*(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) _____

___ 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:_____