Women's Health Hormone Self-Assessment

Weigh Less, Live Longer: Quality | Innovation | Experience | Since 2007

Consulting Practitioner: _____ Consultation Date: _____

How did you hear about Thrive's Bio-Identical Hormone Replacement Treatments?

Advertisement _____ Books/Articles _____

Another Patient _____ Website _____

Healthcare Provider _____ Other (please specify) _____

Personal Information

Patient Name: _____ Date: _____

Address: _____ DOB _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormone Replacement is? _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement? _____ *It is recommended that you consult with your physician regarding these risks.

What are your goals for Biologically Identical Hormone Replacement? _____

_____

_____

Medical History

Family History	(relationship)
Cancer (type) _____	_____
Heart Disease	_____
Diabetes	_____
High Blood Pressure	_____
Osteoporosis	_____
Other	_____

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Medical History (Cont)

Personal History

- ☐ Blood Clots
- ☐ Uterine Fibroids
- ☐ Smoking History
- ☐ Impaired Liver Function
- ☐ Endometriosis
- ☐ Fibrocystic Breasts
- ☐ Abnormal Vaginal Bleeding
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Cancer (type) _____
- ☐ Ovarian Cysts
- ☐ PCOS
- ☐ Other _____
- ☐ Other _____
- ☐ Heart Disease

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Osteoporosis

Cholesterol Serum:_____Date:_____ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Bone density scan results: _____Date: _____

Current Health Care Provider/s:_____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating					
Can't Sleep (Insomnia)					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight gain/ Bloating					
PMS					
Night Sweats					
Difficulty Remembering Things					
Brain Fog/ Burned out Feeling					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
Lack of Sexual Desire					
Fatigue/Loss of Energy					

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General Health & Lifestyle

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ Do you exercise, describe: _____

Menstrual Cycle: ☐ None ☐ Regular _____ Date of last period: _____

☐ Irregular / Explain (heavy, how long,etc): _____

Surgery:	Date of Surgery:	
☐ Oophorectomy	_____	(ovaries)
☐ Hysterectomy	_____	(uterus)
☐ Tubal Ligation	_____	
☐ Other	_____	
☐ None	_____	

Current Medications & Reason: _____

_____

_____

Current Vitamins / Minerals / Herbal Formulas: _____

_____

_____

Prior Hormone Replacement Therapy History: (include dates of use) _____

_____

Known Allergies (drug, food, pollen): _____

Are you currently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc): _____

_____

Do you eat/drink soy: _____ Caffeine/amount per day: _____ Alcohol/amount per day: _____

Notes and/or Questions:

_____

_____

BHRT Considerations

BHRT Dosage Form:
Would you prefer your treatment using a Prescription filled using a:

- ☐ Sub-dermal Pellet Administered once every 3-4 Months (Women) or 4-6 Months (Men)
- ☐ Topical gel applied once daily to inner arms or Thighs.
- ☐ Sublingual tablets dissolved under the tongue twice daily.

Baseline hormone levels must be checked. This can be achieved by testing blood within the Thrive Health and Wellness clinic location or at a LabCorp or Quest Diagnostics lab center. We test for the following hormones:

Women (For overall health check a,b, and c yearly.)

a. Pap Smear
b. Thyroid: TSH, T3, and T4 c. Cortisol
d. Testosterone (Free & Total)
e. Progesterone
f. Estradiol, and Estrone
g. DHEA (Sulfate)
h. Vitamin D3 (25 Hydroxy)

Optional: Reverse T3 (practitioner discretion)

If you have recently (within 1-2 months) had a blood hormone test (including all of the above items), please bring them along with your questionnaire to your scheduled consultation within the clinic at Thrive.

Where to go from here:

- ☐ I would like a consultation and recommendation from a Thrive Health and Wellness, LLC Practitioner.
  - ✓ Please Call Thrive Health and Wellness at (303) 790-8446 to schedule a consultation.
- ☐ I will take this completed questionnaire to my practitioner.
- ☐ I will contact my practitioner about further lab testing.

Notes and/or Questions:

_____

_____

_____

_____

Waiver
I hereby release Thrive Health and Wellness, LLC, all its employees, associates and pharmacists from any and all liability whatsoever associated with or connected with my Biologically Identical Hormone Replacement Therapy (BHRT), consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with BHRT. I understand that no doctor, practitioner, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial infarction, stroke, and breast cancer possibly associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed_____ Date _____

Privacy Agreement
Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at Thrive Health and Wellness, LLC. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all of our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

In an effort to ensure that there will not be a delay in your first treatment from Thrive Health and Wellness, LLC, and that you are provided with prompt service, we ask that you read and sign the Notice of Privacy Practices Acknowledgment form at the bottom of the page and return to us.

For Privacy Agreement Questions, please contact the
clinic at: Thrive Health and Wellness, LLC
88 Inverness Circle E, Bldg A, Ste 204
Englewood, CO 80112
Fax: (303) 799-8175
e-mail: info@thrivecolorado.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____
Patient Last Name Patient First Name M.I.

_____ _____ _____
Street Address City State

_____ (_____)_____
Zip Telephone Number

My signature below certifies and acknowledges that I have read and understand Thrive Health and Wellness's Notice of Privacy Practices.

_____ _____
Patient Signature (or authorized representative) Date

Female Testosterone/Estradiol and/or BHRT Pellet Insertion Consent Form

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

Bio-identical hormone pellets are concentrated 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 made from yam and are FDA monitored but not approved for female hormonal replacement. 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 cannot be given to pregnant women.

My birth control method is: (please circle)
Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

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 similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure.**

Side effects may include: Bleeding, bruising, swelling, infection and pain; 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); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; 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 and 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 agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. 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 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**