LifeTime Health Center
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Dear Patient,

We have designed this questionnaire to learn more about you in order to assist you in achieving your optimum health. We believe a woman's lifestyle, habits, work history and other characteristics are a vital part of the health assessment and your participation in this process will help us better evaluate your test results, risk factors and preventative needs. This information will be placed in a secure file and will NOT be shared with anyone including your insurance company or other entities requesting medical records. If you are uncomfortable answering any of the questions, please feel free to leave the answer blank.
Sincerely,
Rene' McCarty. PAC
Lisa Blackwelder, FNP-C
Brandi Malone FNP-C

Date:_____

Name:_____ Age_____

Allergies:_____

Medications (Include prescriptions, non-prescriptions, herbs and supplements):_____
_____
_____
_____

Childhood Diseases:_____

Transition Test
1. I have inherited negative attitudes about menstruation and menopause from my culture or family. Agree____ Disagree____
2. I have internalized negative cultural ideas about the female body such as thinking of my period as a "rag" or "curse" and enjoyment of sexual activity as shameful. Agree____ Disagree____
3. After my pregnancies, I had postpartum depression. Agree____ Disagree____ Not applicable___
4. My childhood included abandonment, emotional, physical or sexual abuse.

Agree____ Disagree____ Unsure____

5. I try to ignore messages from my body expressed thru symptoms of illness.
Agree____ Disagree____
6. I take care of everyone else and put myself last. Agree____ Disagree____
7. I feel selfish or guilty about taking time for myself. Agree____ Disagree____
8. I am not following my life's purpose in my relationships and work. Agree____ Disagree____
9. I feel that I have no special gifts, strengths, talents or accomplishment.
Agree____ Disagree____

Reproductive Health

I started periods at age____.
Are you currently using contraceptives? What kind:_____
Are you currently trying to get pregnant?_____
First Pregnancy: Age_____ Prenatal Care?_____ Describe course and outcome;
Miscarriage, abortion, vaginal birth or C-section, livebirth_____
_____
Second Pregnancy: Age:____ Prenatal Care?_____ Describe Pregnancy:_____
_____
Third Pregnancy: Age____ Prenatal Care?____ Describe pregnancy:_____
_____
Other Pregnancies:_____
_____
Did you adopt a child or care for a non-biological child during your reproductive years?
_____
_____
Infertility Treatments?_____
My menstrual periods are: Regular (occurring every 28-32 days)_____ or Irregular (describe)_____
Days of flow per period_____ Flow is: light____ moderate____heavy____
My periods stopped at age_____
Describe symptoms during the week of your period: (headaches, backaches, cramping, fatigue, etc.)_____
_____
Have you ever had cysts of the ovaries?_____
Have you ever had cancer of the female organs?_____
Have you ever had abnormal Pap smears?_____ Describe treatment and the diagnosis:_____
When was your last pap smear?_____
Have you ever had problems with the uterus such as abnormal bleeding or fibroids?__
_____
Have you had a hysterectomy?____ Do you still your ovaries?_____
When did you have it?_____
Have you had problems with the vulva or vagina?_____
_____

Breast Health

Do you perform self breast exam?____ How often?_____

Did you breast feed your children? _____ How long?_____
Do you have breast pain, tenderness or discharge?_____
Have you ever had a mammogram or ultrasound of the breast?_____
Date of last physical exam?_____ Date of last mammogram?_____
Have you ever had a breast biopsy?_____
Have you ever been diagnosed with breast cancer?_____ Describe diagnosis and treatment:_____
_____
Have you ever had breast reduction or augmentation (implants)?_____
_____

Sexuality
Are you sexually active?_____ Do you have intercourse?_____
Do you practice safe sex?_____ Are you in a long term relationship?___ How Long?__
Have you ever been diagnosed with a sexually transmitted disease?_____
Have you ever been raped or molested?_____
Did you report it?_____
Do you have any sexual concerns to discuss?_____

Premenstrual Syndrome Questionnaire
Please complete if you are concerned about this condition.
Have you noticed that you experience the following symptoms beginning about 2 weeks before your period each month, with a decrease in symptoms when your bleeding begins?

Mood Changes:
1. Anxiety (feeling of worry, panic out of proportion to usual worries)? Yes__ No__
2. Tearfulness (crying more often or easily)? Yes__ No__
3. Irritability (more short with coworkers, spouse or children)? Yes__ No__
4. Mood swings (angry, sad, happy, anxious)? Yes__ No__
5. Tension (feeling more nervous and tense at work and home)? Yes__ No__
6. Depressed (feeling down, sad, blue)? Yes__ No__

Behavior Changes:
1. Outbursts of anger and rage Yes__ No__
2. Impulsive acts (acting or speaking without thinking of consequences)? Yes__ No__
3. Fatigue (lack of energy, excessive tiredness)? Yes__ No__
4. Craving for sweets or chocolate? Yes__ No__
5. Craving for bread or alcohol? Yes__ No __
6. Craving for salty food? Yes__ No__

Body Changes:
1. Weight gain? Yes__ No__
2. Breast tenderness? Yes__ No__
3. Bloating? Yes__ No__
4. Constipation? Yes__ No__
5. Dizziness? Yes__ No__
6. Low back pain, joint pain? Yes__ No__
7. Headaches? Yes__ No__
8. Heart pounding, beating harder? Yes__ No__

9. Swelling of hands and feet? Yes__ No__

Brain Changes:
1. Change in appetite? Yes__ No__
2. Poor sleep, restless, not restorative? Yes__ No__
3. Change in coordination? Yes__ No__
4. Change in sex interest? Yes__ No__
5. Forgetfulness? Yes__ No__
6. Difficulty in concentrating, staying focused? Yes__ No__
7. Difficulty in decision making? Yes__ No__
8. Memory problems? Yes__ No__

Menopause or Perimenopause
Please complete if you are concerned about these conditions.
Mood Changes:
1. Anxious, overly worried, panicky? Frequent__ Occasional__Rare__
2. Irritable, hypersensitive? Frequent__ Occasional__Rare__
3. Depressed, unhappy? Frequent__ Occasional__Rare__
4. Anger outbursts? Frequent__ Occasional__Rare__

Behavior changes:
1. Feeling unusually fatigued? Frequent__ Occasional__Rare__
2. Tiredness of mind and body? Frequent__ Occasional__Rare__

Body Changes:
1. Loss of luster to skin, hair, nails? Frequent__ Occasional__Rare__
2. Dryness of skin, vagina Frequent__ Occasional__Rare__
3. Hot flushes or flashes? Frequent__ Occasional__Rare__
4. Sweats, followed by being chilled? Frequent__ Occasional__Rare__
5. Pain or aches in joints or muscles? Frequent__ Occasional__Rare__
6. Headaches? Frequent__ Occasional__Rare__
7. Pounding heartbeat of flutters? Frequent__ Occasional__Rare__
8. Skin sensations of crawling insects? Frequent__ Occasional__Rare__
9. Dizziness? Frequent__ Occasional__Rare__
10. Vaginal burning or itching? Frequent__ Occasional__Rare__
11. Pain with urination? Frequent__ Occasional__Rare__
12. Increased frequency of urination? Frequent__ Occasional__Rare__
13. Leaking of urine? Frequent__ Occasional__Rare__
14. Increased urge to urinate? Frequent__ Occasional__Rare__
15. Scalp hair loss? Yes__ No__
16. Sexual interest? Normal__ Decreased__
17. Orgasm? Normal__ Decreased__
18. Pain with sex? Yes__ No__

Brain Changes:
1. Poor sleep, frequent awakenings, poor quality? Yes__ No__
2. Decreased concentration? Frequent__ Occasional__Rare__
3. Forgetfulness? Frequent__ Occasional__Rare__
4. Memory problems (word, names)? Frequent__ Occasional__Rare__

5. “Foggy thinking”, thoughts muddled? Frequent__ Occasional__Rare__
6. Sensations of numbness or tingling Frequent__ Occasional__Rare__

Cardiovascular Health

Do you have any heart valve problems?_____
Do you have high blood pressure?_____
Have you ever had cardiac tests such as a stress test, thallium test, echocardiogram, catheterization, or Holter Monitor?_____
_____
Have you ever been diagnosed with a heart attack?_____
Have you ever been diagnosed with heart failure or heart rhythm problems?_____
_____
Have you ever had your blood cholesterol measured?_____
Have you ever had a blood clot of the leg, arm, or lung?_____
Other cardiovascular concerns?_____

Musculoskeletal Health

Have you ever been diagnosed with a connective tissue, joint, bone or muscle disease?
_____
Have you ever had a bone density test?_____ Results?_____
Do you have trouble sleeping due to joint or muscle pain? Yes___ No___
Do you experience joint or muscle pain on a daily basis? Yes___ No___
Where do you feel joint or muscle pain?_____
Do you experience redness, swelling or heat in the joints? Describe_____
_____
Do you take over-the-counter or prescription pain medicine? Yes___ No___
What and how much?_____
Have you reduced or limited activities due to pain?_____
What makes your pain worse?_____
Do you experience stiffness in the morning? Yes___ No___
Has your pain made you depressed? Yes___ No___

Digestive and Nutritional Health

Have you ever been diagnosed with an illness of the liver, gall bladder, esophagus, pancreas or intestines?_____
Have you ever had testing of the digestive tract such as ultrasound, X-Ray, colonoscopy or sigmoidoscopy?_____
Have you had surgeries of the digestive organs?_____
Do you have indigestion or reflux?_____
Do you experience abdominal pain or bloating after meals?_____
How often do you have a bowel movement?_____
Do you have hemorrhoids or fissures?_____
Do you take laxatives? Describe:_____
Do you take over the counter medications or herbs for digestive symptoms?_____
Describe:_____
Any other digestive concerns?_____
Are you satisfied with your current body weight? Yes___ No___
Do you feel fat most of the time? Yes___ No___
Do you avoid letting your spouse see you without clothes? Yes___ No___

Do friends and family tell you that you are too thin? Yes___ No___
Do you restrict the amount of food you eat daily to control your weight? Yes___ No___
Do you use laxatives or diuretics to control your weight? Yes___ No___
Are you preoccupied with your weight? Yes___ No___
Do you exercise to keep your weight down? Yes___ No___
Have you made yourself vomit to keep from gaining weight? Yes___ No___
Have you had weight fluctuations of more than 10 lbs due to binging and fasting? Yes___ No___
Do you buy food secretly and consume it secretly? Yes___ No___
Do you feel ashamed about your eating habits? Yes___ No___
Do you end eating binges by falling asleep, vomiting or laxative use? Yes___ No___
Describe your typical diet and food choices:
Breakfast:_____
Lunch_____
Dinner_____
Snacks_____
Caffeine intake_____ Carbonated beverages_____

Skin Health
Please describe any "yes" answers.
Have you ever had skin lesions removed?_____
Do you wear sun screen?_____
During childhood or adolescence did you sun bathe or sunburn?_____
Have you had laser treatments to your face?_____
Do you bruise easily?_____
Do you experience dryness or wrinkling of the skin?_____
Do you have dark spots on the face or arms?_____
Any changes in your hair of nails?_____
Any chronic rashes?_____
Describe your skin care routine and use of cosmetics_____
_____

Stress Scale
Please answer and score each answer as directed.
___ Give yourself 10 pts if you feel you have a supportive family member near you.
___ Give yourself 10 pts if you actively pursue a hobby. What is it? _____
___ Give yourself 10 pts if you belong to a social group or activity group outside of your family that meets at least monthly. What group?_____
___ Give yourself 15 pts if you are within five pounds of your ideal body weight for your height and bone structure.
___ Give yourself 15 pts if you practice some form of "deep relaxation" at least three times a week (meditation, prayer, yoga, imagery).
___ Give yourself 15 pts for each time you exercise 30 mins or more during the week.
___ Give yourself 5 points for each nutritionally balanced meal you consume on an average day.
___ Give yourself 5 pts if you do something that you enjoy that is just for your pleasure each week.
___ Give yourself 10 pts if you have someplace in your home that you can relax and be alone.
___ Give yourself 10 pts if you practice time management techniques in your daily life.
___ Subtract 10 pts for each pack of cigarettes you smoke in an average day.

___ Subtract 5 pts for each evening in the course of an average week that you take any form of medication, chemicals or alcohol to help you sleep.
___ Subtract 10 pts for each day during the course of an average day that you consume any form of medication, chemical substance or alcohol to reduce your anxiety or help calm you down.
___ Subtract 5 pts for each evening during the course of an average week that you bring work home.
___ Subtract 5 pts for each day during the course of an average week that you overeat or binge to cope with feelings of anger, anxiety or depression.
_____ Total Score. (Maximum 115)

Headache Questionnaire
Please complete if headaches are a problem for you.
Describe location and type of headache pain:_____
_____
Do foods or chemicals cause your headaches?_____
Are headaches connected to the menstrual cycle?_____
What time of the day do headaches occur?_____
How frequently do headaches occur?_____
How long do headaches last?_____
What relieves the headaches?_____
How long have you been experiencing headaches?_____
With the headache, do you experience sensitivity to light, loud noise or smells?_____
_____
Does stress worsen your headaches?_____
What sort of medical treatment have you received for headaches?_____
_____
Are headaches associated with numbness or weakness of the arms, legs or face?_____
_____
Do you have changes in vision associated with headaches?_____
Do you take over the counter medicine for headache? How Much?_____
_____

Well-Being Assessment
From Screaming to be Heard, by E. Vliet, M.D.
Describe an experience in which you had the feeling of being totally alive._____
_____
_____
_____
What makes you feel that life is really worth living?_____
_____
What are 5 things that you like about yourself?_____
_____
What are 5 things that you feel you do well?_____
_____
List 5 things in your life you are happy with and do not want to change._____
_____
_____
What are 5 things you are not happy with and want to change?_____
_____

Which of the things in the previous list are in your control and which are not in your control?_____
Do you feel that you contribute positively to the lives of others? How?_____
_____
_____
What are 5 ways you can improve or maintain your well being without the assistance of others?_____
_____
What are your most important aspirations?_____
_____
What are some self-destructive or self-defeating behaviors that you want to stop?_____
_____
What are several things that you tell yourself that you "should" do or "ought to" do that you really do not want to do?_____
_____
_____

Habits and Lifestyle
Who lives in your household?_____
Any pets?_____
Describe your neighborhood and living environment._____
_____
Do you feel safe in your house and relationships?_____
Where (region/city) did you spend most of your childhood?_____
Adulthood?_____
How many hours do you sleep at night?_____
Do you smoke cigarettes? How much?_____
Have you ever stopped smoking? Describe:_____
Do you drink alcohol to excess or use mood altering drugs more than 3-4 times a year?
_____
In the past year, have you failed to do your work or take responsibility due to drinking too much alcohol or drug use?_____
Have you needed to use alcohol other drugs in the morning to 'get you going'?_____
_____
Do you feel remorse after using alcohol or other mood altering drugs?_____
_____
How often in the past year have you been unable to remember what happened the night before because you had been drinking or using drugs?_____
Have you or someone else been injured as a result of your drinking or drug use?_____
Has a friend or family member asked you to cut down or stop drinking/using?_____
Have you ever experienced blackouts?_____
Do you have a home computer?_____
How many hours a day do you use your computer?_____
What percent of time for: Correspondence_____ Shopping_____ Education_____
Entertainment/Leisure_____ Other (describe)_____
Do you feel that you spend too much time using your computer?_____
How many hours of television do you watch a day?_____

Occupational Health
What is your current occupation or occupation prior to retirement?_____
Describe you education._____
Describe your work or volunteer environment._____
_____
How many hours a week do you work or volunteer?_____
Are you satisfied with your work or volunteer situation?_____
If you are experiencing physical symptoms, please answer the following questions:
Do you have a condition that has failed to respond to standard treatment or is of unknown cause?_____
Are your symptoms different at home and work?_____
Are you currently, or have you been in the past exposed to chemicals, viruses, radiation, noise, repetitive work, or unusual stress in the work environment? _____
_____
Are any of your co-workers experiencing similar symptoms?_____

Safety Assessment
Do you wear a seat belt all the time?_____
Are you trained in CPR?_____
Do you have a home first aid kit?_____
Do you have smoke detectors in your home?_____
do you have fire extinguishers in your home?_____
Do you keep guns unloaded and locked away?_____

Travel Assessment
Have you traveled overseas? Where and when?_____
_____
Have you ever been diagnosed with a tropical illness?_____
Have you received vaccines or medications for foreign travel?_____

Spiritual Travel
What in your life gives you internal support?_____
What are your sources of hope, strength, comfort and serenity?_____
_____
What sustains you during difficult times?_____
Are you worried about any conflicts between your beliefs and your medical care or medical decisions made by your providers?_____
_____
Are there any practices or restrictions I should know about as your healthcare provider?
_____
Have you made plans for end of life care?_____

Conclusion
Is there anything else that you wish to share about your past or present health concerns?_____
_____
_____
_____

CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

Background:

You have been diagnosed with or have an increased risk of having a hormone deficiency (ies) and your Provider has recommended treatment with bio-identical hormone replacement therapy (HRT). Some of the bio-identical hormone preparations that may be prescribed for you are regulated by pharmacy compounding laws, which follow the Pharmacy Compounding Accreditation Board (PCAB) guidelines. The use of this therapy as it relates to your diagnosis, while common in alternative practices, may be debated in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so you make an informed decision whether or not to undergo the procedures after knowing the risks involved. This disclosure is not meant to scare or alarm you, but to simply inform you so you have the information needed to give or withhold your consent to the procedure or treatment.

NOTICE: Refusal to consent to the innovative, integrative, complementary or non-standard procedure shall not affect your right to future care or treatment.

Therapeutic Basis:

Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. Bio-identical HRT can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.

q Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease hot flashes and night sweats, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.

q Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. For males, low dose progesterone therapy in conjunction with testosterone therapy can maximize the hormone ratios, reducing unwanted side effects.

q Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your Provider. Low testosterone is associated with elevated cholesterols, high blood pressure, diabetes, and prostate problems. Other low testosterone symptoms include excessive fatigue, abdominal weight gain, irritability and decreased sexual drive and function.

Objectives:

Bio-identical HRT is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:

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.

q Estrogen Therapy: Bio-identical estrogens are available in various forms including oral capsules, troches, patches, pellets and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings. High potency conjugated estrogens (e.g. Premarin) have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

q Progesterone Therapy: Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

q Testosterone Therapy: Bio-identical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, pellets and injection. Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with the use of bio-identical hormones.

Statement of Patient:

I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a LTHC Provider, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to my Provider any adverse reaction or problem that might be related to my therapy. Risks and 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 hormone treatments, and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient _____ Date_____

Name (PRINT) _____

Statement of Provider:

I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy.

I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed the patient has no further questions and wishes to initiate bio-identical hormone replacement therapy.

Name of PROVIDER Explaining Procedures: _____

PROVIDER Signature_____