Patient Info

Name____
Last Middle First

Address_______________________ Height________ Weight________ Sex M / F

City__________________ State______ Zip ________ DOB________ Age_____ Marital Status________

Phone________________ Email________________ Occupation________________

Allergies:

Medications, OTC, Vitamins:

Medical Conditions/Diseases (Please check all that apply)

______ Heart disease - Type:________________
______ High cholesterol or lipids
______ High blood pressure
______ Thyroid disease
______ Liver disease
______ Osteoporosis
______ Uterine Fibroids/Ovarian Cysts
______Lung disease
______Ulcers
______Arthritis or joint problems
______Headaches/migraines
______Persistent urinary tract infections
______Abnormal vaginal bleeding
______Blood clots (i.e. DVT, PE)
______Cancer - Type:________________
______Diabetes
______Depression
______Endometriosis
______Fibrocystic breast
______Stroke
______Other – Please list:

Do you have a history or family history of any of the following?

	Yes	No	Family Member(s)
Uterine Cancer	O	O	______
Ovarian Cancer	O	O	______
Breast cancer	O	O	______

Have you had any of the following procedures/exams?

	Yes	No	Date
Hysterectomy (uterus)	O	O	______
Oophorectomy (ovaries)	O	O	______
Tubal Ligation	O	O	______
Sexually transmitted infections	O	O	______

Have you had any of the following?

	Yes	No	How many?
Preganancies	O	O	______
Miscarriages	O	O	______
Children	O	O	______

Do you use any of the following?

	Yes	No	If yes, how often and how much
Alcohol	O	O	______
Tobacco	O	O	______
Soy	O	O	______
Caffeine	O	O	______
Other	O	O	______

Have you had any of the following exams?

	Yes	No	Date/Result
Mammography	O	O	______
PAP Smear	O	O	______
Pelvic ultrasound	O	O	______
Bone density scan	O	O	______

Please answer the following questions

	Yes	No	How many?
Do you plan to have more children?	O	O	______
Are you currently breastfeeding?	O	O	
Are you currently pregnant?	O	O	
Are you currently sexually active?	O	O	

Name____
Last Middle First

Please answer the following questions

Have you ever used contraceptives? oYes oNo

If yes, please list medication, dose, directions, and duration of treatment. ______________________________

Did you have any problems? If yes, please explain. ______________________________

Have you ever used hormone replacement therapy? oYes oNo

If yes, please list medications, dose, directions, and duration of treatment. ______________________________

Did you have any problems? If yes, please explain. ______________________________

Do you exercise? oYes oNo

If yes, please describe your routine. ______________________________

Do you currently follow a special diet? oYes oNo

If yes, please explain. ______________________________

Please answer according to if you are currently cycling or when your were cycling.

Date of last period ______________________________

How many days does your period last? ______________________________

Do you have heavy cycles? If yes, please explain. oYes oNo ______________________________

Do you have regular cycles? If no, please explain oYes oNo ______________________________

How many days is your menstrual cycle? ______________________________

What are you top three goals for starting Hormone Replacement Therapy?

1. ______________________________
2. ______________________________
3. ______________________________

'atient Signature______________________________ Date______________

Patient Info

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Phone______________________ DOB________________

Mild ← Moderate → Severe

	(Please Circle)										
Sleep Disruption	NA	1	2	3	4	5	6	7	8	9	10
Irritability	NA	1	2	3	4	5	6	7	8	9	10
Nervousness	NA	1	2	3	4	5	6	7	8	9	10
Mood swings	NA	1	2	3	4	5	6	7	8	9	10
Depression	NA	1	2	3	4	5	6	7	8	9	10
Cramps	NA	1	2	3	4	5	6	7	8	9	10
Breakthrough bleeding	NA	1	2	3	4	5	6	7	8	9	10
Hot flashes	NA	1	2	3	4	5	6	7	8	9	10
Night sweats	NA	1	2	3	4	5	6	7	8	9	10
Vaginal dryness	NA	1	2	3	4	5	6	7	8	9	10
Painful intercourse	NA	1	2	3	4	5	6	7	8	9	10
Breast tenderness	NA	1	2	3	4	5	6	7	8	9	10
Fluid retention	NA	1	2	3	4	5	6	7	8	9	10
Headaches	NA	1	2	3	4	5	6	7	8	9	10
Decreased sex drive	NA	1	2	3	4	5	6	7	8	9	10
Harder to reach climax	NA	1	2	3	4	5	6	7	8	9	10
Decreased motivation	NA	1	2	3	4	5	6	7	8	9	10
Decreased self-confidence	NA	1	2	3	4	5	6	7	8	9	10
Fatigue	NA	1	2	3	4	5	6	7	8	9	10
Loss of recent memory	NA	1	2	3	4	5	6	7	8	9	10
Dry skin	NA	1	2	3	4	5	6	7	8	9	10
Arthritis	NA	1	2	3	4	5	6	7	8	9	10
Hair loss	NA	1	2	3	4	5	6	7	8	9	10
Urinary incontinence	NA	1	2	3	4	5	6	7	8	9	10
Weight gain	NA	1	2	3	4	5	6	7	8	9	10

Patient Signature______________________________ Date__________

Female

Estrogen Dominance/Progesterone Deficiency Questionnaire

This questionnaire lists symptoms and other factors most commonly found in women suffering from this condition. By answering this questionnaire, your scores will determine whether or not you might have estrogen dominance/ progesterone deficiency. If you answer yes to any of the questions listed, please circle the number to the right of the question and total your score separately at the bottom of each table.

Question	Score
Do you have premenstrual breast tenderness?	4☐
Do you have premenstrual mood swings?	4☐
Do you have premenstrual fluid retention and weight gain?	4☐
Do you have premenstrual headaches?	4☐
Do you have migraine headaches?	3☐
Do you have severe menstrual cramps?	4☐
Do you have heavy periods with clotting?	3☐
Do you have irregular menstrual cycles?	3☐
Do you have uterine fibroids?	3☐
Do you have fibrocystic breast disease?	3☐
Do you have endometriosis?	2☐
Have you had problems with infertility?	2☐
Have you had more than one miscarriage?	2☐
Do you have joint pain?	1☐
Do you have muscle pain?	1☐
Do you have decreased libido?	3☐
Do you have anxiety or panic attacks?	2☐

Total ______

If your total score is **less than 4 points**, it is not likely that you have estrogen dominance/ progesterone deficiency. Scoring **between 5-8 points** indicates estrogen dominance/progesterone deficiency. A score **between 9-20 points** indicates estrogen dominance/progesterone deficiency is likely. A score **above 20 points** would suggest that estrogen dominance/ progesterone deficiency is very likely.

Perimenopausal and Menopausal Symptoms of Low Estrogen Questionnaire

This questionnaire lists symptoms and other factors most commonly found in women who are either perimenopausal or menopausal, and suffering from low estrogen. By answering this questionnaire, your scores will determine whether or not you might have low estrogen.

Question	Score
Do you have hot flashes?	4☐
Do you have night sweats?	4☐
Do you have vaginal dryness?	3☐
Do you urinate frequently?	2☐
Are you depressed?	2☐
Do you have difficulty sleeping?	3☐
Have you lost interest in sex?	2☐
Have your periods ceased?	4☐

Total ______

If your total score is **less than 4 points**, it is not likely that you have low estrogen. Scoring **between 5-9 points** indicates low estrogen is likely. A score **above 9 points** would suggest that low estrogen is very likely.

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Yeast Overgrowth Questionnaire

This yeast questionnaire lists symptoms and other factors most commonly found in people suffering from **yeast overgrowth**. By answering this questionnaire, your scores will determine whether or not you might have yeast overgrowth. If you answer yes to any of the questions listed, please circle the number to the right of the question and total your score separately at the bottom of each table.

Question	Points
Do you have fatigue?	3 ☐
Do you feel lethargic?	2 ☐
Have you taken antibiotics multiple times during your life?	3 ☐
Do you have abdominal bloating, cramping or gas?	3 ☐
Do you have indigestion or heartburn?	2 ☐
Do you have abnormal bodily reactions to wine, beer or alcoholic beverages (i.e. flushing, headaches, sinus congestion or itchy skin)?	2 ☐
Do you crave sugar or bread products?	2 ☐
Do you have difficulty concentrating?	1 ☐
Do you have depressed moods?	1 ☐
Do you develop skin rashes or hives?	2 ☐
Do you have athlete's foot?	4 ☐
Do you have jock itch?	4 ☐
Do you have rectal itching?	3 ☐
Do you have fungal infection under the toenails or fingernails?	3 ☐
Do you have allergy symptoms?	1 ☐
Do you have recurrent respiratory infections?	1 ☐
Do you have joint pain?	1 ☐
Do you have muscle pain?	1 ☐
Do you have recurrent vaginal yeast infections?	4 ☐

Total _____

If your score is **less than 9 points**, it is not likely that you have yeast overgrowth. Scoring **between 10-16 points** indicates yeast overgrowth is a possibility. A score **above 16 points** indicates that yeast overgrowth is very likely.

Adrenal Fatigue Questionnaire

This questionnaire lists symptoms and other factors most commonly found in people suffering from adrenal fatigue. By answering this questionnaire, your scores will determine whether or not you might have adrenal fatigue.

Question	Points
Do you have fatigue?	3 ☐
Do you have allergies?	3 ☐
Do you have asthma?	3 ☐
Do you have recurrent infections?	3 ☐
Are you under severe emotional stress?	3 ☐
Do you suffer from chronic pain or physical?	3 ☐
Do you have low blood pressure?	2 ☐
Do you have a low pulse rate (less than 70 bpm without exercise)?	2 ☐
When you rise quickly, do you feel as though you might pass out?	2 ☐
Do you have depressed moods?	2 ☐
Do you have joint pain?	2 ☐
Do you have muscle pain?	2 ☐
Do you have low libido?	2 ☐
Do you have hair loss?	2 ☐
Do you have anxiety attacks?	2 ☐

Total _____

If your total score is **less than 6 points**, it is not likely that you have adrenal fatigue. Scoring **between 7-12 points** indicates adrenal fatigue is a possibility. A score **above 12 points** would suggest that adrenal fatigue is very likely.

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Low Thyroid Questionnaire

This questionnaire lists symptoms and other factors most commonly found in people suffering from low thyroid or hyperthyroidism. By answering this questionnaire, your scores will determine whether or not you might have low thyroid. If you answer yes to any of the questions listed, please circle the number to the right of the question and total your score separately at the bottom of each table.

Question	Score
Do you have fatigue?	4 ☐
Do you have elevated cholesterol?	4 ☐
Do you have difficulty losing weight?	2 ☐
Do you have cold hands and feet?	2 ☐
Are you sensitive to the cold?	2 ☐
Do you have difficulty thinking?	2 ☐
Do you find it hard to concentrate?	2 ☐
Do you experience brain fog?	2 ☐
Do you have poor short term memory?	2 ☐
Are your moods depressed?	2 ☐
Are you experiencing hair loss?	2 ☐
Do you have less than one bowel movement per day?	2 ☐
Do you have dry skin?	2 ☐
Does your skin itch in the winter?	1 ☐
Do you have fluid retention?	2 ☐
Do you have recurrent headaches?	1 ☐
Do you sleep restlessly?	1 ☐
Are you tired when you awaken?	2 ☐
Do you have afternoon fatigue?	2 ☐
Do you have experience tingling or numbness in your hand or feet?	2 ☐
Do you have decreased sweating?	2 ☐
Have you had problems with infertility or miscarriages?	2 ☐
Do you have recurrent infections?	2 ☐
Do your muscles ache?	2 ☐
Do you have joint pain?	2 ☐
Do you have thinning of your eyebrows or eyelashes?	2 ☐
Is your tongue enlarged with teeth indentations?	2 ☐
Is your skin pasty, puffy or pale?	2 ☐
Do you have decreased body hair?	2 ☐
Is your voice hoarse?	2 ☐
Do you have a slow pulse?	1 ☐
Do you have a low blood pressure?	2 ☐
Does your body temperature run below the normal 98.6?	2 ☐
Do you have sleep apnea?	4 ☐
	2 ☐

Total _____

If your total score is **less than 10 points**, it is not likely that you have low thyroid. Scoring **between 11-30 points** indicates low thyroid as a possibility. A score **above 30 points** would suggest that low thyroid is very likely.

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Nuwave Medical, PLLC

Patient Name: ______________________________ Date: ______________

Informed Consent
For Bioidentical Hormone Replacement Therapy (BHRT)

It is important for you to be aware of the potential risks, as well as the benefits, before deciding on whether to begin Bioidentical Hormone Replacement Therapy. You should also be aware of alternatives to BHRT including not receiving the treatment. Any questions that you may have should be brought to our attention. Your provider will answer all of your questions to your satisfaction prior to starting treatment.

Directions: Initial beside each statement that you have read, understand, and agree with.

___ 1. This is my consent for Nuwave Medical, PLLC, including any physician, PA or NP who works with the practice, to begin my treatment of BHRT.

___ 2. It has been explained to me, and I fully understand, that occasionally, as with any medical treatment, there can be side effects or complications:

___ 3. Fluid retention – This can cause problems for patients with heart, kidney, or liver disease.

___ 4. Sleep disturbance – This is called sleep apnea and is more likely to occur with patients who have lung disease or who are obese.

___ 5. Changes in cholesterol levels, red blood cell levels, liver function or other hormone levels.

___ 6. I understand that Nuwave Medical, PLLC will therefore perform periodic blood tests to monitor my blood levels.

___ 7. I understand that the results of this treatment are not guaranteed and that if I stop treatment, my condition may return or worsen.

___ 8. I have had an opportunity to discuss my complete past medical history with Nuwave Medical, PLLC. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with the answers.

___9. I understand that the initial and periodic physical exams performed by Nuwave Medical, PLLC do NOT replace a full physical exam performed by my personal health care provider.

___10. I therefore agree to have my personal health care provider perform a yearly full physical exam. If I do not have a personal health care provider, Nuwave Medical, PLLC will assist in locating one for me.

___11. I agree to provide NuWave Medical PLLC. copies of my most recent Pap smear, Mammogram, Transvaginal Ultrasound & Bone Density Test.

____
Patient Date

____
Witness Date