OC HEALTH
& HORMONE BALANCE

FEMALE PATIENT INTAKE FORM

PATIENT INFORMATION

Name:________________________ Date:________________________

Date of Birth:______________ Age:__________ Weight:__________ Occupation:______________

Sex: ☐ Male ☐ Female ☐ Prefer not to Share

Marital Status (Check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single

Home Address:____

City:____________________ State:______________ Zip:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Preferred Contact Number:____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email Address:________________________ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact:____________________ Relationship:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Primary Care Physician's Name:________________________ Phone:______________

Address:____

City:____________________ State:______________ Zip:______________

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak to your spouse or significant other about your treatment.

Name:________________________ Relationship:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

PATIENT HISTORY

Social:

☐ I am sexually active **OR** ☐ I want to be sexually active **OR** ☐ I do not want to be sexually active

☐ I have completed my family **OR** ☐ I have not completed my family

☐ My sex life has suffered **OR** ☐ I have not been able to have an orgasm or it is very difficult

Habits (Select all that apply):

☐ I smoke cigarettes or cigars____per day.

☐ I use e-cigarettes____a day.

☐ I use caffeine

☐ I drink alcoholic beverages____per week.

☐ I drink more than 10 alcoholic beverages a week.

Activity Level: Select all that apply):

☐ Low (Sedentary)

☐ Moderate (Walk/jog/workout infrequently)

☐ Average (Walk/jog/workout 1 to 3 times per week)

☐ High (Walk/jog/workout regularly 4+ times per week)

PATIENT INFORMATION (Continued)

Drug Allergies:

Drug Allergies: ☐ Yes ☐ No

If yes, please explain: ____________________

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No

Medication currently taking: ____________________

Current hormone replacement? ☐ Yes ☐ No

If yes, what? ____________________

Past hormone therapy: ____________________

Family History (Select all that apply):

☐ Heart Disease

☐ Diabetes

☐ Osteoporosis

☐ Alzheimer's/Dementia

☐ Breast Cancer

☐ Other

Birth Control Method:

☐ Menopause

☐ Hysterectomy

☐ Tubal Ligation

☐ Birth Control

☐ Infertility

☐ Other

MEDICAL HISTORY

Select all that apply:

Cardiovascular Conditions:

☐ Heart Attack or Stroke (within last 6 months)

☐ Tachycardia (elevated heart rate)

☐ DVT or Blood Clot (within last 6 months)

☐ Hypertension (high blood pressure)

☐ Hyperlipidemia (high cholesterol)

☐ Obstructive Sleep Apnea

☐ Atrial Fibrillation

☐ Irregular Heartbeat

Gynecological Conditions:

☐ Pre-Menstural Syndrome

☐ Endometriosis or History of Endometriosis

☐ Fibrocystic Breast Disease

☐ Fibroids or History of Fibroids

☐ Polyps or History of Polyps

☐ Irregular or Heavy Periods

☐ Ovarian Cysts

Cancer:

☐ Breast Cancer or History of Breast Cancer

☐ Endometrial Cancer

☐ Cervical Cancer

☐ Ovarian Cancer

☐ Thyroid Cancer or History of Thyroid Cancer

☐ Except for Basal Cell Carcinoma, Any Other Cancers?

Neurological Conditions:

☐ Epilepsy or Seizure Disorder

☐ Depression/Anxiety

☐ Psychiatric Conditions

☐ Migraine with Aura

☐ Meningioma

Endocrine and Metabolic:

☐ PCOS

☐ Diabetes Type 2 or Insulin Resistance

☐ Hyperthyroid (high thyroid)

☐ Hypothyroid (low thyroid)

☐ Multiple Endocrine Neoplasia Type-2

☐ Hair Thinning or Hair Loss

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MEDICAL HISTORY (Continued)

Autoimmune Conditions:

☐ Diabetes Type 1
☐ Hashimoto's Thyroiditis
☐ Graves' Disease
☐ Rheumatoid Arthritis
☐ Multiple Sclerosis
☐ Systemic Lupus (Erythematosus)
☐ Psoriasis
☐ IBS (Irritable Bowel Syndrome)
☐ Chron's Disease
☐ Ulcerative Colitis

Organ Specific Conditions:

☐ Liver Disease or History of Liver Disease
☐ Kidney Disease or History of Kidney Disease
☐ LAM (Lymphangioleiomyomatosis)
☐ Osteoporosis or Osteopenia
☐ HIV
☐ Hepatitis
☐ Hemochromatosis
☐ Pancreatitis or History of Pancreatitis
☐ History of or Gallbladder Disease
☐ Polycythemia Vera (PV)

SYMPTOMS AND CONCERNS

Select all that apply:

☐ Hot Flashes
☐ Night Sweats
☐ Vaginal Dryness
☐ Decreased Interest in Sex
☐ Inability To or Delayed Orgasm
☐ Painful Intercourse
☐ Urinary Incontinence
☐ Frequent Urinary Tract Infection
☐ Breast Tenderness
☐ Weight Gain
☐ Hair Loss
☐ Hair Thinning
☐ Thinning Eyebrows

☐ Cold Hands or Feet
☐ Brittle Nails
☐ Dry or Flaking Skin
☐ Lack of Energy (Fatigue)
☐ Decreased Muscle Mass
☐ Acne
☐ Facial Hair
☐ Dry Eyes
☐ Joint Pain
☐ Difficulty Sleeping
☐ Mind Racing at Bedtime
☐ Eating When Stressed

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FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: ______________________ TODAY'S DATE: ______________________

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)					
Sleep Problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)					
Decline in drive or interest (loss of "zest for life," feeling down or sad)					
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Vaginal dryness or difficulty with sexual intercourse					
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)					
Sweating (night sweats or increased episodes of sweating)					
Hot Flashes (burst that starts in chest and lasts for short duration)					
Hair loss, thinning or change in texture of hair					
Feeling cold all the time, having cold hands or feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					

Other symptoms or unique health circumstances to take into consideration:

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: ____

Signature: ____Date:_____________________________________

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

The hormones used in the pellets are made at a compounding pharmacy. Compounding drugs, as defined by the FDA, is "the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. The FDA does not approve these individualized compounded medications. In most cases, insurance does not cover bioidentical compounded pellets.

We require payment at the time of service and, if you choose, we will provide a form to send to your insurance company with a receipt that you paid out of pocket. This form and receipt serve as evidence of your treatment. Our office does not submit these forms to your insurance company.

For patients who have access to a Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. Please request the receipt and paperwork to submit for reimbursement if needed.

New Patient Office Fee $125.00
Includes Initial Consultation and Telehealth Follow-Up Appointment
(Required over the phone to book/Refundable if cancelled within 24 hours of appointment date)

Female Hormone Pellet Insertion Fee $475.00
Creams/Patches $95/month
(Enrolled in automatic monthly billing)
Testosterone Injections $150/month
(Enrolled in automatic monthly billing)

We accept the following forms of payment: Visa, Mastercard, Checks and Cash

Print Name: ____

Signature: ____

OC Health & Physical Medicine
18017 Skypark Cir., Ste F
Irvine, CA 92614
(949) 862-7499

Appointment Cancellation Policy

It is our desire to provide you with the best possible care and attention that we can offer. For this reason, our officeøs cancellation policy is designed to help our patients and staff maintain a tight and efficient schedule.

We request a **24-hour notice** if you need to reschedule or cancel your appointment. The best way to let us know after hours is to either: send us a text via Demand Force, call us and leave a voicemail, or e-mail us at **Frontdesk@ochealth.net**. You will receive a courtesy confirmation text (2 Days) prior to your scheduled appointment.

*****Appointments that are missed (No-Show) or Cancelled less than 24 hours from the scheduled time will incur a charge of the following:**

Consultations and/or Pellets $95 **Testosterone Injections $25**

Pellet procedure: Please arrive 10-15 minutes prior to your scheduled appointment time to complete pre-treatment paperwork.

I have read, understood, and received a copy of the Appointment Cancellation Policy of OC Health & Physical Medicine and agree to its terms.

Patient (Print Name) ______________________ Signature ______________________ Date ______________

Pellet Appointment Policy

Due to an increase in schedule and patient volume, it is now more important than ever that all patients arrive on time for their pellet appointments.

Effective Immediately:
We will be enforcing a **10-minute grace period** for all pellet appointments. Patients are required to **arrive at least 10-15 minutes prior** to their scheduled appointment time in order to complete the required consents at each visit.

If you arrive more than 10 minutes late, your appointment will be **rescheduled**, and a **$95 late fee** will be applied. This fee must be **paid in full before rebooking** your next appointment.

This policy is enforced out of respect for your time, the time of fellow patients, and Stephanie's professional commitments. We sincerely appreciate your understanding and cooperation as we endeavor to maintain punctuality and provide the highest standard of care to all patients.

By signing below, you acknowledge that you have read, understood, and agree to abide by this policy.

Patient Name: ____

Signature: ____

Date: ____________________