NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability.

Date _____

Patient Name _____ **Birth Date** _____

Home Phone _____ **Work or Cell Phone** _____ **Email** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

How did you hear about us? _____

Describe your main complaint(s) _____

_____

If your complaint is due to pain, complete the following:

Location _____ **Severity on a scale of 1** _____ **10**

Quality _____ **Duration** _____

Time _____ **What makes it better or worse?** _____

Do you have any other health concerns? _____

MEDICAL HISTORY: List any other doctors you've seen for this condition _____

Who is your current family physician? _____ **Specialist?** _____

Date of your last physical exam _____ **When did you have your last blood tests?** _____

List any diagnoses or treatments _____

List any surgeries or major illness with date of occurrence _____

Have you had any infectious diseases? _____

Have you been hospitalized for this or any condition? _____

Do you have any allergies? _____ **Have you ever reacted to medications?** _____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking _____

_____

NUTRIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements _____

_____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

- **Do you exercise? How often?** _____ **What type?** _____
- **Do you use alcohol? How often?** _____ **What kind?** _____
- **Do you smoke? How much?** _____ **For how long?** _____ **When did you quite?** _____
- **Do you drink coffee?** _____
- **Do you drink caffeinated sodas?** _____
- **Do you follow a specific diet?** _____
- **Are you concerned about your weight? Are you following a specific diet?** _____
- **Do you overeat? How is your appetite?** _____ **Do you have any reactions to foods?** _____
- **Do you crave sweets? Do you have any other food cravings?** _____ **Or aversions?** _____
- **Are you concerned about aging? Do you have a specific concern?** _____
- **Are you concerned about your appearance? Have you used any aesthetic therapies?** _____
- **Are you stressed or anxious?** _____
- **Do you or have you experienced depression? Is there any form of depression or dementia in your family?** _____
- **Do you suffer from insomnia or any other form of sleep abnormality?** _____
- **Are you concerned about memory loss?** _____
- **Do you practice any form of stress reduction such as meditation, tai chi or yoga?** _____
- **Is your relationship fulfilling?** _____ **How is your children's health?** _____
- **Do you experience fatigue?** _____

DIETARY INFORMATION: Describe your daily diet _____

_____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know _____

BIOMARKER QUESTIONNAIRE

Age _____ Sex_____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- ☐ Decreasing muscle mass
- ☐ Reduced strength
- ☐ Decreased joint mobility
- ☐ Increased stiffness
- ☐ Reduced capacity for work and exercise
- ☐ Decreased endurance
- ☐ Significant weight loss
- ☐ Increased body fat
- ☐ Increased waist to hip ratio (more fat deposits on the abdomen and waist)
- ☐ Reduced sexual drive and/or performance
- ☐ Muscle mass loss or flabbiness
- ☐ Changes in body temperature
- ☐ Sensitivity to cold or heat
- ☐ Hot flashes
- ☐ Dryer or thinning skin and hair
- ☐ Brown or red spots
- ☐ Spider veins on the skin
- ☐ Slow wound healing
- ☐ Frequent colds or flu
- ☐ Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis
- ☐ Chronic pain or inflammation
- ☐ Poor sleep
- ☐ Waking up tired
- ☐ Fatigue
- ☐ Longer recovery time needed after exertion
- ☐ Forgetfulness
- ☐ Increasing difficulty concentrating
- ☐ Mood changes
- ☐ Unexplained depression
- ☐ Anxiety
- ☐ Increased anger or irritability
- ☐ Sensitivity to certain foods
- ☐ Craving for sugar
- ☐ Alcohol intolerance

Have you had any of the following tests?

- ☐ Complete Blood Count
- ☐ Chemistry Panel
- ☐ PSA (Prostate Specific Antigen) and prostate exam for men over 40
- ☐ Breast Exam and Mammography (for women)
- ☐ Pap Smear / uterine / ovarian scan (for women)
- ☐ Colonoscopy
- ☐ Basal Temperature
- ☐ 3-5 hour Glucose Tolerance Test
- ☐ Fasting insulin
- ☐ Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL
- ☐ Thyroid Studies (TSH, T4)
- ☐ Free T3
- ☐ Homocysteine
- ☐ Blood Pressure
- ☐ Bone Density
- ☐ Treadmill Test / EKG / ECHO
- ☐ Estrogen levels
- ☐ Testosterone
- ☐ Free testosterone
- ☐ IgF-1 (a marker for human growth hormone)
- ☐ DHEA-S
- ☐ Cortisol
- ☐ SHBG (sex hormone binding globulin)

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

- ☐ Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- ☐ Atherosclerosis (hardening of the arteries) _____
- ☐ High cholesterol or other form of abnormal lipids _____
- ☐ Heart attack or stroke _____
- ☐ Diabetes or any form of metabolic disease or obesity _____
- ☐ Cancer and list type(s) _____
- ☐ Osteoporosis or any form of bone disease _____
- ☐ Thyroid disease _____
- ☐ List any other diseases in your family _____

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

- ☐ Exhausted feelings that are not related to stress or amount of work or exercise.
- ☐ Morning tiredness, even after a full night's sleep.
- ☐ Depression that does not respond to antidepressants, diet, or exercise.
- ☐ Unexplained anxiety and panic attacks.
- ☐ Been told that I move as if in slow motion, and take too long to responds to questions.
- ☐ A frequently low or hoarse voice (for a woman).
- ☐ Mental sluggishness and have difficulty focusing.
- ☐ Low sex drive and do not experience significant sexual arousal.
- ☐ High cholesterol that has been unresponsive to diet or medications.
- ☐ A tendency to feel cold even in warm weather.
- ☐ Chronic aches and pains not due to accidents or exercise.
- ☐ Carpal tunnel syndrome
- ☐ Problems with allergies.
- ☐ Difficulty losing weight and keeping it off.
- ☐ Very dry skin.
- ☐ I have acne or eczema.
- ☐ Diabetes
- ☐ Rheumatoid arthritis or other autoimmune condition.
- ☐ Problem with my periods, including abnormal menstrual bleeding.
- ☐ Anemia
- ☐ Infertility or a history of frequent miscarriages.
- ☐ Significant menopausal symptoms.
- ☐ A tendency to have chronic constipation even with a high fiber diet.
- ☐ Lots of hair falling out or brittle hair.
- ☐ Vitiligo or other unusual changes in skin color.
- ☐ Trembling of my hands or stumbling for no reason.
- ☐ Have a family history of thyroid disorder
- ☐ Have previously been diagnosed with a thyroid disorder

FOR WOMEN ONLY: Confidential History

Name _____ Date _____

Age _____ Birth Date_____ Height _____ Weight _____ Date of last physical examination_____

What are you main health concerns? _____

_____

MENSTRUAL & GYNECOLOGICAL SYMPTOM REVIEW

How old were you when you had your first period start? _____ Did you have any problems then?

_____

How was your period in your twenties? _____Thirties? _____

How is your period now (if you still are menstruating)? _____

Do you have any PMS symptoms? If yes, what are they?

_____

Do you have menopausal symptoms?

_____

Are you experiencing mood changes with menopause?

_____

Name of your gynecologist _____Date of last Pap smear _____

Have you had a mammogram? And when?_____ A bone density study (DXA scan)? _____

Number of children _____ Are you pregnant now? _____ Attempting pregnancy? _____

Do you have fibroids? _____ Size _____ Date of last sonogram _____

Ovarian cysts? _____ Breast cancer? _____

Is your cholesterol high? _____Other cardiovascular risk factors_____

Do you have osteoporosis or osteopenia? ___ Do you have any urinary tract complaints?_____

Do you have any vaginal complaints? _____How is your libido? _____

Other complaints? _____

_____

MEDICATION REVIEW

What medications do you currently take? _____

Are you using prescription hormones? _____

Do you use any natural hormone preparations? _____

What nutritional supplements do you take? _____

Have you had any adverse reactions to medications? _____

PATIENT SIGNATURE: _____ **Date** _____

ANTI AGING SKIN CARE QUESTIONNAIRE

Do you have any concerns regarding the aging of your skin such as (check all that apply):

- ☐ Excessively dry skin
- ☐ Wrinkling skin
- ☐ Large Pores
- ☐ Red/Flushed skin
- ☐ Visible Blood Vessels
- ☐ Wrinkling around the eyes
- ☐ Deepening folds around the mouth
- ☐ Dark circles and puffiness around the eyes
- ☐ Adult acne

Are you currently using facial products that contain any of the following ingredients (Check all that apply):

- ☐ Vitamin C
- ☐ Retinol
- ☐ AHA
- ☐ Peptides
- ☐ Vitamin A
- ☐ Anti-oxidants

Have you ever had any of the following treatments (Check all that apply):

- ☐ Chemical Peels
- ☐ Skin Care Treatments
- ☐ Laser treatments
- ☐ Facial surgical procedures
- ☐ Dermabrasion

BHRT Consent

Name:_____

Address:_____City:_____State:_____Zip:_____

DOB:_____

Primary Doctor:_____

Natural or Bio-identical Hormone Replacement Therapy is the therapeutic use of hormones that are identical to the hormones made naturally by the body.
There are many different type but the ones used predominantly in our clinic include: testosterone, progesterone, estrone (E1), estradiol (E2), estriol (E3),
DHEA, androstenedione, cortisol, thyroid and melatonin. These hormones are typically used to treat symptoms of perimenopause, menopause, andropause
(male menopause or low testosterone), thyroid dysfunction and adrenal fatigue (cortisol) although other symptoms may be treated as well.

Female patients:
The Women's Health Initiative Study (WHI) studied 16,608 postmenopausal women aged 50-79 years old with an intact uterus. The women received either Premarin
(0.625mg), Prempro (0.625/2.5mg), or placebo daily. These hormones were non human, non bioidentical hormones.
Users of Premarin and Prempro had :
• 41% more strokes (29 HRT VS 30 placebo in 10,000 person years)
• 29% more heart attacks (37 HRT VS 30 placebo in 10,000 person years)
• twice as many blood clots (34 VS 16 placebo in 10,000 person years)
• 26% more breast cancer (38 VS 30 placebo in 10,000 person years)
• 66% increase in Alzheimer's Dementia (45 HRT VS 22 in 10,000 person years)
• 37% less colorectal cancer (0.63 relative risk reduction)
• 33% fewer hip fractures (0.66 relative risk reduction)
The average age of the study participants was 63 years of age, and on average started hormone therapy 12 years after menopause. Synthetic hormones
(ex. Progestins), and bioidentical hormones such as progesterone have different effects on the body.
Bioidentical hormones can be used and metabolized as our body was designed to do, minimizing side effects. Bioidentical hormone dosages can be fine
tuned to your specific needs. Many European studies suggest that bioidentical hormones are safer than synthetic hormones. However, that doesn't mean
that bioidenticals are perfect. We also do not have any large scale, double blinded, placebo controlled trials on bioidenticals.
Relative Contraindications: personal family history of breast, ovarian, or endometrial cancer and a strong family history of breast or ovarian cancer. Close
collaboration with an oncologist may be needed in these situations. Unexplained vaginal bleeding may be another contraindication.
Precautions: BHRT does not increase heart disease risk if given at the proper dosage and ratio. Patients with previous deep vein thrombosis require careful
monitoring if they are taking oral estrogen. Women with known heart disease need routine evaluation and annual labs including cholesterol levels and EKG.
They will need to be followed up by their primary care physician for this condition.

Baseline hormone levels are ordered at your initial visit. You will then be given an individualized prescription of BHRT based on your symptoms and test
results. Symptom resolution is not immediate. It can take anywhere from 3-9 months until patients feel like they have the perfect fit. There are many different
preparations of BHRT (topical creams, sublingual troches, vaginal inserts, pills, and sublingual drops). Some women respond to one form better than another.
Saliva or serum / blood tests are measured every 2-4 months until stable. When stable, hormone levels are then monitored every 6-12 months depending on the situation.
Patient's bodies and lifestyles change and so do their hormonal needs. Hormones are usually measured via saliva, serum and or urine samples. Neurotransmitters are also evaluated in some situations and are done via a urine sample.
You are required to have pap smears (as frequently as indicated), mammograms, and DEXA Scans (as indicated). It is required that you supply us with a

copy of these results for our records. Hormones are generally not prescribed or renewed unless these records are up to date

Male patients:
Men on testosterone therapy
are required to have their testosterone levels checked **at least** every three months for the first year and then at least twice per year thereafter. Levels may
be checked more often depending on response to therapy.
Male are also required to have digital rectal exam by primary physician and PSA levels prior to starting hormone and every 3 months while on treatment.

Bio-identical hormones are made at compounding pharmacies. BHRT is generally not reimbursed by
insurance companies although there are exceptions. On request, the pharmacy will provide you with a form that you can fill out and submit to your insurance
company for reimbursement. Many women generally use anywhere from one to five hormone preparations.
Many times we can combine 2 or 3 hormones into one preparation once we have the correct dose for each of the individual hormones. This will help keep the cost down.
We also require that you have a current primary care physician to manage all you other health needs.

I understand and agree to the above statements and all my questions have been answered to my satisfaction. I am consenting for bio-identical hormone
treatment at Affinity Medspa and Wellness Center .

I understand that the treatment for bio-identical hormones at Affinity Wellness 4 Life by Dr. Michael P. Heim and Dominic Sorrentino PA-C, AAAHP is an out of network service.

Payment will be due at the time of initial service. Initial full 1st and 2nd visit is $325.00 and f/u visits are $150.00-175.00 every 3-4 months for 1st year then every 6 months thereafter. This does not include added costs for medications or supplements if needed.

Patient Signature_____ Date_____

Printed name _____

Physician / Practitioner _____ Date_____

AFFINITY WELLNESS 4 LIFE
beauty | weight loss | hormones

AFFINITY WELLNESS 4 LIFE
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Financial Disclosure

The consultation fee includes the initial and 2nd visit, comprehensive medical history, physical exam (including blood pressure, heart rate, temperature, weight and body fat analysis), "one on one" assessment of laboratory results, bio-identical hormone replacement advisement and diet, supplementation and exercise advice.

Laboratory testing (including blood, salivary and urine testing) is NOT INCLUDED in the initial fee. NON-INSURED PATIENTS estimated fee for labs is $200- $500 depending on tests considered.
INSURED PATIENTS WILL BE RESPONSIBLE FOR ANY FEES THAT YOUR INSURANCE COMPANY DOES NOT COVER AND IF UNSURE OF COVERAGE TO CONTACT APPROPRIATE CARRIER.

Bio-identical Hormone Replacement Therapy (BHRT) prescriptions and any other prescriptions and supplements are also not included in the initial fee and are the responsibility of the patient.

I understand that I am financially responsible for all laboratory fees or fees not covered by my insurance company. I also understand that I am also financially responsible for all prescriptions and supplements. (Initial) _____

All sales are FINAL. No transfers, exchanges or misuse of any product or services rendered other than the original patient of whom they are intended for. (Initial) _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date