Past Medical History

Patient Name: _____ Today's Date: _____

PAST MEDICAL HISTORY:

❒ HTN ❒ DM 1/2 ❒ Hyperlipidemia ❒ Hypothyroidism ❒ Chronic Fatigue Sx ❒ Infertility

❒ Breast Cancer ❒ Gynecomastia ❒ Heart Disease ❒ Asthma/COPD ❒ Anemia ❒ DVT/PE

Other: _____

PAST SURGICAL HISTORY:

❒ Vasectomy ❒ Cholecystectomy ❒ Appendectomy

Other: _____

_____

_____

LAST PSA: Date: _____ Results: ❒ Normal ❒ Abnormal

FAMILY HISTORY:

❒ Breast Cancer ❒ Ovarian Cancer ❒ Colon Cancer ❒ Heart Disease ❒ Lung Disease

❒ Prostate Cancer ❒ Diabetes Mellitus ❒ Hypertension ❒ Stroke ❒ Blood Clots

Other: _____

_____

_____

SOCIAL HISTORY:

Tobacco: ❒ Yes ❒ No How often? _____ Years _____ QUIT? _____

Alcohol: ❒ Yes ❒ No How much? _____

Illicit Drug Use: ❒ Yes ❒ No How often? _____

Use of hormone supplements (gels, creams, pills, injections): _____

_____

Patient's Physician: _____

Okay to send "Dear Doctor" letter? Yes_____ No_____

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Patient Profile (1 of 2)

First Name: _____ Last Name: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed Date of Birth: _____

Email: _____ May we contact you by email? ❒ Yes ❒ No

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Day Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____ Cell Phone: _____

Ethnicity: ❒ African American ❒ Asian ❒ Caucasian ❒ Hispanic ❒ Native American ❒ Middle Eastern Other:_____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Spouse/Partner Name: (if applicable) _____ Phone Number: _____

Spouse Employer: _____ Address/Phone Number: _____

How did you hear about us? _____

What are your expectations of Bioidentical hormone treatments? _____

Check all that apply:

❒ Anxiety	❒ Autoimmune Disease	❒ Cancer	❒ Endocrine Disorder
❒ Hepatitis	❒ Prostate Surgery	❒ Mood Swings	❒ HRT
❒ Thinning Hair	❒ Blood Clots	❒ Liver Disease	❒ Aches/Pains
❒ Palpitations	❒ Hypertension	❒ Shingles	❒ Diabetes
❒ Thyroid Disorder	❒ Weight Gain	❒ Erectile Dysfunction	❒ Jaundice
❒ High Cholesterol	❒ Night Sweats	❒ Blood Diseases	❒ Dry Skin
❒ Heart Disease	❒ Vasectomy	❒ Restless Leg Syndrome	❒ Suffered Stroke
❒ PMS	❒ Renal Disease		
❒ Low Blood Pressure	❒ Smoker	❒ Alcohol Drinker _____ (Per Week?)	

Height:_____ Weight:_____ Desired Weight:_____ Are you presently dieting? ❒ Yes ❒ No Which Diet? _____

Current Meds, Vitamins, or Herbal Remedies: _____

Surgical History: _____

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Patient Profile (2 of 2)

First Name: _____ Last Name: _____

Primary Care Physician: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Do you exercise regularly? ❒ Yes ❒ No What exercise program do you follow? _____

How often do you work out? _____

What other activities do you do in your leisure time? _____

Do you play any sports? ❒ Yes ❒ No What sports do you play? _____

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I hereby authorize Dr. Huber to apply for benefits on my behalf for services rendered by him. I request payment from my insurance company (companies) to be made to Dr. Huber. I understand that if my insurance covers only a portion of the charges, I will be responsible for the balance of the fees. I also understand that if the insurance claim is denied, I will be billed for the entire amount of the charges. If payment is not made by my insurance company within sixty (60) days from the date of the claim submission, I agree to promptly pay in full any amounts due to Dr. Huber. If full payment of the outstanding balance on my account is not paid within sixty (60) days of notification, I agree to pay any interest and/or late charges levied on my balance. In the event my account becomes overdue, I will be responsible for attorney's fees as well as expenses which are related to collection efforts.

I certify that the information I have read with regard to my insurance coverage is correct and authorize the release of any information, including medical information and photographs, to my insurance company (companies).

Please print name: _____

The above information is true to the best of my knowledge:

PLEASE SIGN _____ Date _____

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Symptoms (Male)

Patient's Name: _____ Today's Date: _____

SYMPTOM	NONE	OCCASIONAL	MODERATE	SEVERE
Hot Flashes				
Fatigue				
Night Sweats				
Low Libido				
Insomnia				
Irritable				
Mood Swings				
Weight Gain				
Depression				
Anxiety				
Difficulty Losing Weight				
Poor Exercise Tolerance				
Cold Body Temperature				
Cold Hands & Feet				
Hair Loss				
Joint Pain				
Loss of Muscle Mass				
Visual Changes				
Panic Attacks				
Erectile Dysfunction				
Memory Lapses				
Bone Loss				
Water Retention				
Dry Skin				
Urinary Incontinence				
Headaches				
Tearful				
Thinning Skin				
Foggy Thinking				
Increased Facial Hair				
Oily Skin				
Allergies				
Acne				
Heart Disease				
Decreased Concentration				
Insulin Resistance				
Swelling/Puffy Eyes				
Sugar Craving				
High Blood Sugar				

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