





## Alabama Family Practice, P.C.

### Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC)


### Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

### Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past?  Yes  No

- If yes, how many packs per day? \_\_\_\_\_
- How many total years have you smoked? \_\_\_\_\_

Do you drink alcohol?  Yes  No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? \_\_\_\_\_

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)?  Yes  No

- If yes, what substance(s) and how often? \_\_\_\_\_

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<b>Urological History</b>		
Date of last prostate exam? _____ Physician who performed? _____		
Physician's Phone Number _____		
Date of last mammogram? _____ Facility where performed: _____		
Facility Phone Number: _____		
	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had elevated PSA? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a prostate biopsy?		
Do you have a history of any of the following cancers:		
<input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Lymphoma <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Prostate		

<b>Hormone Therapy History</b>				
Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:				
Hormone	Dose	Reason	Start Date	Stop Date

<b>Androgen Deficiency</b>	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> Low Libido <input type="checkbox"/> Lack of Energy <input type="checkbox"/> Decreased Strength/Energy <input type="checkbox"/> Lost Height <input type="checkbox"/> Decreased Enjoyment of Life <input type="checkbox"/> Sad or Grumpy <input type="checkbox"/> Problem with Memory/Concentration	<input type="checkbox"/> Decreased Erections <input type="checkbox"/> Decreased Ability to Play Sports <input type="checkbox"/> Fall Asleep After Dinner <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Recent Deterioration of Work Performance <input type="checkbox"/> Decreased Muscle Mass <input type="checkbox"/> Hair Loss

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<b>Adrenals</b>		
Check which of these symptoms are troublesome and have persisted over time		
<b>Cortisol Excess</b>		<b>Cortisol Deficiency</b>
<input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Bone Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain – Waist <input type="checkbox"/> Loss of Muscle Mass <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Headaches <input type="checkbox"/> Stress <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Low Libido <input type="checkbox"/> Hair Loss <input type="checkbox"/> Increased Facial Hair <input type="checkbox"/> Increased Body Hair <input type="checkbox"/> Acne <input type="checkbox"/> Nervous	<input type="checkbox"/> Fatigue <input type="checkbox"/> Sugar Craving <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical Sensitivity <input type="checkbox"/> Stress <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Irritable <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Aches/Pains

<b>Thyroid</b>	
Check which of these symptoms are troublesome and have persisted over time	
<b>Thyroid Excess</b>	<b>Thyroid Deficiency</b>
<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Voice has become hoarse <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Weight Loss <input type="checkbox"/> Tremors/Shakiness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nervousness/Anxious/Panic Attacks <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Difficulty Conceiving/Infertility <input type="checkbox"/> Coarse Dry Skin <input type="checkbox"/> Insomnia	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Constipation <input type="checkbox"/> Fatigued/Weakness <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> Inability to Lose Weight <input type="checkbox"/> Stress <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Irritable <input type="checkbox"/> Lack of Motivation <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Aches/Pains

<b>System Review – Check the appropriate box for each question.</b>			
<b>Constitutional / ID / Oncology</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
<b>Respiratory</b>			
Do you have a persistent cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema or sleep apnea?			

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<b>System Review</b> – Check the appropriate box for each question.			
<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition?			
Have you ever been diagnosed with a blood clot?			
<b>Gastrointestinal</b>			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
<b>Endocrine</b>			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
<b>Neurological</b>			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
<b>Urologic / Renal</b>			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			
Physician Notes:			

## **Disclosure / Liability Waiver**

### **Alabama Family Practice, P.C. – Bio-Identical Hormone Replacement Program**

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Alabama Family Practice, P.C. It's staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## **Maintenance of Preventative Medicine and Cancer Surveillance**

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a prostate examination and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date