MD WELLNESS CENTER AND MED SPA

Dr. Srinivasu Kesa, MD
American Board of Obesity Medicine
www.MyTrimMD.com
contact@mytrimmd.com

6822 E 82ND ST. SUITE #300 INDIANAPOLIS IN 46250 317.548.4666 317.650.2501 317.350.0059

Sexual Wellness Questionnaire For Women

Name: _____

DOB: _____ Ph. No: _____

Email: _____

Mailing Address: _____

What is your main concern?	☐ Lack of desire? ☐ Lack of arousal? ☐ Pain on intercourse? ☐ Lack of orgasm?	**Please Explain:**
Cancer or blood clots	☐ Breast Cancer History In First-Degree Relatives ☐ Breast Cancer History ☐ Deep Venous Thrombosis.	
How long have you been having symptoms?	☐ Less Than Six Months. ☐ More Than Six Months.	
Do you have sexual fantasies or thoughts?		
Can you maintain sexual desire through sexual activity?		
Do you participate in sex or initiate a sexual encounter?		
Are these symptoms more recent?		
Do you have any pain during intercourse?		
Are you interested in sex, or is it a lack of desire?		
Is there any stress in life when these symptoms started?		
Have you had any pelvic surgeries in the past?		
Did you have complicated pregnancies in the past?		
Can you reach orgasm?		
Do you have DM or HTN for a long time?		

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Any depression or anxiety?		
Have you ever had genital Herpes?		
Did these symptoms start after Hysterectomy?		
What medications do you take?	☐ Pain meds? Ex opioids ☐ Anti-allergy meds? Ex Claritin etc. ☐ Any psychiatric medications? ☐ Sedative' s-ex benzos ☐ Cardiac- ex - amiodarone, clonidine, Aldactone, digoxin, Fenofibrate, Lopid, Methyl dopa ☐ Seizure medications- Neurontin, GnRH, Reglan, Dilantin, Topamax ☐ Ketoconazole **OTC'S -** ☐ Supplements ☐ Any recreational drugs?	***Please list all your meds, including OTC's or supplements***
Do you have any chronic heart or lung diseases that will prevent you from being active?		
What is your Effort tolerance? How much can you walk or how many stairs can you climb?		
Is there any history of abuse or trauma in the past or childhood?		
What Treatment options would you prefer?	☐ Nasal spray ☐ Topical creams ☐ Injections	

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Sexual Wellness Treatment Consent Form

I _____ authorize Midwest Wellness LLC and Dr.Kesa and whomever they designate as their assistants, to help me with my sexual wellness. I understand that my program may consist of hormone replacement, injections, Topicals, nasal sprays, troches, and behaviour modifications. It also involves regular blood tests, having Up-to-date Mammogram and PAP smears.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with these treatments. Risks of this program may include but are not limited to the side effects of hormone replacements and medication reactions. Also, treatment does not guarantee that all patients will see the results. And as we use natural products, results will be slow and gradual.

I understand that the program's success will depend on my efforts and that there are no guarantees or assurances that the program will be successful.

I have read and fully understand this consent form, and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given the time I need to read and understand this form.

For medication refills, you need to be seen and have proper blood tests done at regular intervals. For controlled substances, you need to be seen on a monthly or alternate month basis. For other refills, you need to be seen every 90 days _____

If you have any questions regarding the proposed treatment's risks or hazards or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Time: _____

Witness: _____ Patient: _____
(Or a person with authority to consent for the patient)

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Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

MD Medical Weight Loss and Wellness Center appreciates the confidence you have shown in choosing us to provide your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. Payment is required at the time services are rendered. We accept payments in cash, check, credit cards, HAS cards, and FSA cards.

I have read the above policy regarding my financial responsibility to MD Medical Weight Loss and Wellness Center for providing services to the above-named patient or me. I certify that the information is, to the best of my knowledge, true and accurate.

Patient Signature: _____ Date: _____

Guarantor Signature: _____

Save Now