MD WELLNESS CENTER AND MED SPA

Dr. Srinivasu Kesa, MD
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6822 E 82ND ST. SUITE #300 INDIANAPOLIS IN 46250 317.548.4666 317.650.2501 317.350.0059

Intake Form Women

Personal Information:

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormones Replacement is?

_____

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as myocardial infarction, heart disease, stroke, breast cancer?

_____

What are your goals for Biologically Identical Hormone Replacement?

_____

_____

_____

Medical History:

Family History	**Relationship**
☐ Cancer (type) _____	_____
☐ Heart Disease	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____
☐ Osteoporosis	_____
☐ Other	_____

Personal History

☐ Blood clots	☐ Fibrocystic Breasts	☐ Ovarian Cysts
☐ Uterine Fibroids	☐ Abnormal Vaginal Bleeding	☐ PCOS
☐ Smoking History	☐ Stroke	☐ Previous abnormal Mammogram

Save Now

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☐ Impaired Liver Function ☐ Thrombophlebitis ☐ Previous abnormal PAP smear

☐ Endometriosis ☐ Cancer (type)_____ ☐ Breast cancer

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

☐ Osteoporosis

Bone density scan results: _____ Date: _____

Current Health Care Provider/s:

_____

To What Degree Do You Experience The Following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating	☐	☐	☐	☐	☐
Insomnia (Cannot sleep)	☐	☐	☐	☐	☐
Depressed or Unhappy	☐	☐	☐	☐	☐
Anxious	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Moodiness/Emotional Swings	☐	☐	☐	☐	☐
Painful or Swollen Breasts	☐	☐	☐	☐	☐
Weight gain/Bloating	☐	☐	☐	☐	☐
PMS	☐	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐	☐
Difficulty Remembering Things	☐	☐	☐	☐	☐
Brain Fog	☐	☐	☐	☐	☐

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Hot Flashes	☐	☐	☐	☐	☐
Vaginal Dryness	☐	☐	☐	☐	☐
Dry Hair/Skin	☐	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐	☐
Frequent Urinary Tract Infections	☐	☐	☐	☐	☐
Inability to Reach Orgasm	☐	☐	☐	☐	☐
Painful Intercourse	☐	☐	☐	☐	☐
Lack of Sexual Desire	☐	☐	☐	☐	☐
Fatigue/Loss of Energy	☐	☐	☐	☐	☐

General Health & Lifestyle

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ Do you exercise, describe: _____

Menstrual Cycle: None Regular Date of last period: _____

☐ Irregular/Explain (heavy, how long, etc.): _____

Surgery: **Date of Surgery:**

☐ Oophorectomy _____

☐ Hysterectomy _____

☐ Tubal Ligation _____

☐ Other _____

☐ None _____

Current Medications & Reason:

_____

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_____
_____
_____

Current Vitamins/Minerals/Herbal Formulas:

_____
_____
_____
_____

Prior Hormone Replacement Therapy History: (Include dates of use)

_____
_____
_____
_____

Known Allergies: (drug, food, pollen)

_____
_____
_____
_____

Do you eat/drink soy: _____ Caffeine/amount per day: _____
Alcohol/amount per day: _____

Sleep:

_____

Notes and/or Questions:

_____
_____
_____
_____

BHRT Considerations:

BHRT Dosage Form
Would you like your medication as --?

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1. Topical gel applied once daily to inner arms or thighs

   _____

2. Sublingual tablets dissolved under tongue twice daily

   _____

3. Subcutaneous pellets once every few months

   _____

It is recommended that the baseline hormone level be checked. This can be achieved by testing blood, urine, or saliva. If recommended, we suggest that you test for the following hormones:

Labs needed to start on treatment---

☐ a. Pap Smear/ Mammogram

☐ b. Thyroid: TSH, T3, and T4

☐ c. Cortisol

☐ d. Testosterone (Free & Total)

☐ e. Testosterone (Free & Total)

☐ f. Estradiol and Estrone

☐ g. DHEA (Sulfate)

☐ h. Vitamin D3 (25 Hydroxy)

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Notes and/or Questions:

_____

_____

_____

Waiver & Privacy Information

Waiver

I hereby release MD Medical Weight Loss and Wellness Center, all its employees and pharmacists from any and all liability whatsoever associated with or connected to my Biologically Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with HRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination and appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial

infarction, stroke, and breast cancer possibly associated with BHRT use. I have answered all of the questions on this questionnaire truthfully.

Signed _____ **Date** _____

Privacy Agreement:

Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at MD Medical Weight Loss and Wellness Center. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all of our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

To ensure that there will not be a delay on your first prescription from MD Medical Weight Loss and Wellness Center and that you are not provided with prompt service, we ask that you read our Notice of Privacy Practices, sign the Acknowledgement form at the bottom of the page and return to us.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

MD Medical Weight Loss and Wellness Center Indianapolis, IN 46250

_____	_____	_____
Patient Last Name	**Patient First Name**	**M.I.**
_____	_____	_____
Street Address	**City**	**State**
_____	_____	
Zip Code	**Telephone Number**	

My signature below certifies that I have been provided with a copy of the above-named Notice of Privacy Practices.

_____ _____

Patient Signature (or authorized representative) **Date**