34941 US Hwy. 19 N, Palm Harbor, FL 34684

PH: 727.210.4940 • Fax: 727.771.7694

Medical Health Questionnaire

❑ **New Patient** ❑ **Name Change** ❑ **Address Change** ❑ **Insurance Change**

ALL SECTIONS MUST BE COMPLETED FOR ALL PATIENTS: Today's Date_____/_____/_____

Patient Name: ____
Last First Middle Initial

Date of Birth: _____/_____/_____ Age: _____ Sex: ❑ Male ❑ Female

ADDRESS:
Mailing Address: ____
Street City State Zip

Secondary Address: ____
Street City State Zip

Home Phone: ( ) ____________________ Work Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Emergency Contact Phone: ( ) ____________________ Email Address: ______________________________________
Occupation: ____

Primary Care Physician: ______________________________ Referred by: ______________________________________

How Did You Hear About Us? ____

LIFESTYLE FACTORS:

Occupation:______________________________________ _**Hours worked per week?**______________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Physical Activity

Type:	**Duration:**	**Intensity:**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Sleep
How many hours per night do you sleep?
____

Do you wake up often?____
If so, how many times?____
Reason for waking?____

STRESS

Do you experience an unusual amount of stress on a daily basis?
____
____

Methods used to relieve stress?

____
____
____

Weight History:
Height: ______________ **Current Weight:** _______________ **Highest Weight** _________ **Ideal Weight** _______________

Family Medical History (Circle all that apply)

High Blood Pressure Heart Attack Stroke Blood Clots Bleeding Tendencies

Diabetes Glaucoma Muscular Degeneration Osteoporosis

Breast Cancer Colorectal cancer Thyroid Disorder Depression

Bipolar Manic Depressive Alcohol Abuse Substance Abuse

Dementia or Alzheimer's Disease Celiac

Surgeries or Hospitalizations
Year___________________________ Reason ______________________________________

Major Illness or Injuries
Year _______________________________ Reason___________________________________

Personal Medical History (Circle all that apply)

Endocrine: Thyroid Disease Adrenals Pituitary Diabetes

Respiratory: Asthma Emphysema Pulmonary Emboli

Musculoskeletal: Arthritis Osteoporosis Back or Spine Problems Carpal Tunnel

Mental Health: Depression Anxiety Schizophrenia ADHD Bipolar Substance Abuse Alcoholism

Genitourinary: Kidney Stones Impotence Infertility Menopause Fibroids Ovarian Cyst

Polycystic Ovarian Syndrome Endometriosis

Gastrointestinal: Ulcers Malabsorption Diverticulosis Hepatitis Liver Disease Lactose Intolerance

Cardiac Concerns: Heart Attack Angina Arrhythmia High Blood Pressure Heart Murmur

High Cholesterol

Cancer: Type: ______________________________ When: _______________________________

General: Glaucoma Epstein-Barr Chronic Fatigue

Neurology: Seizures Headaches Migraines Stroke

Social History:

Do you smoke? _______________________________

If so, what type: ____

How much do you smoke? ____

Do you want to quit? ____

Do you drink alcohol? ____

If so, how many drinks per week? ____

What do you drink? ____

Do you drink caffeine products (coffee, tea, energy drinks, soda)? ____

How many per day? ____

Date of last physical exam? _________________________ Date of last PSA or prostate exam? _____________________________

Date of last Pap smear/pelvic exam? ________________________________ Date of last mammogram? ______________________

(Women) Have you had a hysterectomy?_________________________(Men) Have you had a vasectomy?_________________

Medications (please list all prescription and non-prescription medications and nutritional supplements)

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Name: ____ Dosage: _____________________ Frequency _________________

Allergies:

____

____

____

____

Typical daily food intake:

	Weekdays	Weekends
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack:		
Midnight Snack:		

Hormone Questionnaire for WOMEN Only:

Symptom	**None**	**Mild**	**Moderate**	**Severe**
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Uterine Fibroids				
Water Retention				
Breast tenderness				
Fibrocystic Breast				
Increased Forgetfulness				
Foggy Thinking				
Tearful				
Depressed				
Mood Swings				
Difficulty Sleeping				
Decreased Stamina				
Anxious				
Irritable				
Nervous				
Fibromyalgia				
Allergies				
Headache				
Sugar Cravings				
Dizzy Spells				
Cold Body Temperature				
Goiter				
Hoarseness				
Dry and Brittle Hair				
Nails Breaking and Brittle				
Constipation				
Slow Pulse Rate				
Rapid Heart				
Heart Palpitations				
Infertility				
Acne				
Increased Facial/Body Hair				
Scalp Hair Loss				
Weight Gain Hips				
Weight Gain Waist				
High Cholesterol				
Elevated Triglycerides				
Decreased Libido				
Decreased Muscle Size				
Thinning Skin				
Ringing in Ears				
Rapid Aging				
Aches and Pains				
Bone Loss				
Decreased Urine Flow				
Decreased Urinary Urge				

Hormone Questionnaire for MEN Only:

Symptom	**None**	**Mild**	**Moderate**	**Severe**
Prostate Problems				
Weight Gain Chest/Hips				
Weight Gain Waist				
Decreased Libido				
Low Androgens				
Decreased Erections				
Ringing in Ears				
High Cholesterol				
Elevated Triglycerides				
Hot Flashes				
Night Sweats				
Decreased Mental Sharpness				
Increased Forgetfulness				
Decreased Muscle Size				
Decreased Flexibility				
Sore Muscles				
Increased Join Pain				
Bone Loss				
Rapid Aging				
Thinning Skin				
Decreased Stamina				
Burned Out Feeling				
Stress				
Morning Fatigue				
Evening Fatigue				
Difficulty Sleeping				
Apathy				
Depressed				
Mental Fatigue				
Anxious				
Irritable				
Nervous				
Headaches				
Sugar Cravings				
Dizzy Spells				
Cool Body Temperature				
Goiter				
Hoarseness				
Dry or Brittle Hair				
Constipation				
Slow Pulse Rate				
Rapid Heart Rate				
Heart Palpitations				
Infertility Problems				
Allergies				

34941 US Hwy. 19 N, Palm Harbor, FL 34684
PH: 727.210.4940 • Fax: 727.771.7694

Consent for Evaluation and Treatment at the Center for Medical Rejuvenation

I authorize and give my Consent to the **Center for Medical Rejuvenation** and its Medical Doctors, and such other medical practitioners, associates, technicians, pharmacists, as well as any other health care personnel of the **Center for Medical Rejuvenation** for the evaluation and treatment of my Medical Weight Loss and/or Hormone Therapy Program by the administration of prescribed medication while under the supervision of the **Center for Medical Rejuvenations** Medical Practitioners.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure, treatment and therapy; including the proposed treatment for Medical Weight Loss and/or Hormone Therapy and that it is not possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known and unknown general risks.

I appreciate, understand, and agree to follow the proposed treatment and therapy as prescribed by the **Center for Medical Rejuvenations** Medical Practitioners without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or other designated therapies that may be prescribed to me possibly more than once daily. Furthermore I consent to periodically have my blood drawn, saliva acquired, or urine specimens obtained for laboratory monitoring and analysis as required by the **Center for Medical Rejuvenations** Medical Practitioners.

I also agree to take medical weight loss, dietary supplements, hormone replacement prescriptions and any other designated therapies as prescribed by the Practitioners. I have completely disclosed my medical history, all non-prescription and prescription medications that I am taking or plan on taking during my treatment, as well as over the counter medications, recreational drugs or social substances, herbs, extracts, and any additional supplements. I completely agree to follow the recommendation to continue or discontinue these preparations. I will receive prior authorization from you in advance before stopping any of the medication or taking any additional prescriptions. I also understand that the use of "social substances" such as tobacco, "street drugs", and alcohol or other types of non-described "social substances" may affect my therapy in a significantly adverse manner or way.

I also understand that the **Center for Medical Rejuvenation** does not bill insurance and that I may be responsible for any laboratory, saliva or urine testing costs during my treatment. I understand that it is my sole responsibility for any and all unpaid balances should they arise, from my insurance company.

By signing this form, I release the **Center for Medical Rejuvenation** of any and all liability. I confirm that I have read this form in its entirety or it has been read to me if I am unable to read it, and I understand there are risks associated with participating in any program offered at the **Center for Medical Rejuvenation**.

In addition, by signing this form, I am confirming that I am not pregnant, breastfeeding, trying to conceive while taking prescription medications, or have any heart conditions that I have not disclosed on the health questionnaire.

___________________________________ ________________________________

Patient Signature Date

___________________________________ ________________________________

Staff Signature Practitioner Signature

34941 US Hwy. 19 N, Palm Harbor, FL 34684

PH: 727.210.4940 • Fax: 727.771.7694

Complimentary Program Evaluation

Today's appointment (15 minute complimentary program evaluation) has been reserved for you to review the Program offered at CMR to determine how we can best meet your needs and which program would be best suited for you in an effort to achieve your goals.

You will be meeting with a board certified practitioner in hormone therapy. After completing your health history you will be seen by a practitioner and provided an explanation of the programs offered at CMR.

Today's visit is not intended to review previous lab work, medical records, make recommendations on current treatment you may be receiving, or give medical advice for future care.

If you decide to proceed with treatment at CMR, then program fees will be collected at the end of the visit. Once enrolled in one of our programs; appropriate lab work will be ordered for you and previous medical records reviewed as applicable to future treatment.

Patient Signature_______________________________Date_________

Staff Signature__________________________________

Patient Financial Policy

Welcome to Center for Medical Rejuvenation, a division of Bay Dermatology and Cosmetic Surgery. We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the Financial Policies as described below.

Payment of Services
Payment for services rendered is ultimately the patient's responsibility. It is YOUR responsibility to give us the correct information regarding personal and billing information. Full payment must be made at the time of service. For your convenience we accept cash, personal checks, most major credit and debit cards. Any refunds will acquire an $85.00 administration fee.

Cancellation/Missed Appointments
Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. We do understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, if you do not cancel your appointment within 24 hours, the following fee schedule will be applied:

1. $25.00 Missed appointment where injections would be administered.
2. $50.00 Routine/follow-up appointments
3. $100.00 Initial Hormone Lab interpretation or Yearly Physical and Wellness visit.

Medical Records Policy
When requesting a copy of medical records, by law, a signed release by the patient, is required whether the copies are sent to another provider or the patient directly.

All patients are provided with a copy of their lab work at the time of review by the practitioner at their scheduled appointment.

Medical records forwarded to a provider directly are at no additional charge. Copies to patients are provided at $1/per page for the first 20 pages, then $.25/for additional pages.

Our staff will be happy to answer any questions you may have about our policies. Thank you for allowing us to serve you.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

X____ ____________________
Signature of Patient or Responsible Party Date