NORTHDALLASWELLNESS CENTER

Hormone Therapy Questionnaire

Name (First, M.I., Last) _____

E-mail_____SSN _____

Address (street) _____

(city)_____(state)_____(zip) _____

Phone (cell) _____Occupation _____

Date of birth_____ Gender: □ Male □ Female

Primary Physician (name)_____

Date of last physical with your physician_____Results _____

LIFESTYLE	**YES**	**NO**	
Do you smoke?	□	□	If yes, how much per day _____
Do you drink alcohol?	□	□	If yes, how much per day _____
Do you drink caffeine?	□	□	If yes, how much per day _____
Do you exercise?	□	□	If yes, please describe _____

FAMILY HISTORY **age; significant health issues**

Father _____

Mother _____

Brothers/Sisters_____

PERSONAL MEDICAL HISTORY

Medical conditions _____

_____

_____

Surgeries _____

_____

Current medications (Name, dosage) _____

_____

_____

_____

Medication allergies_____

_____

Current vitamins and supplements _____

_____

Your local pharmacy name_____Phone number_____

Address _____

HRT/TESTOSTERONE TREATMENT CHECKLIST

	YES	NO		YES	NO
Decreased sense of well-being	☐	☐	Thinning or loss of hair	☐	☐
Difficulty sleeping	☐	☐	Decreased focus and memory	☐	☐
Decreased energy	☐	☐	Decreased skin tone	☐	☐
Lack of motivation	☐	☐	Mood swings	☐	☐
Decreased sex-drive	☐	☐	Sadness, depression	☐	☐
Decreased muscle strength	☐	☐	Hot flashes	☐	☐
Increased fat deposits	☐	☐	Prolonged exercise healing	☐	☐

MEN ONLY

Have you had a bladder or prostate infection in the last 12 months? _____

Date and result of last PSA test (age 50 and older) _____

WOMEN ONLY

Date of last menses_____ Are you menopausal? _____ Number of live births _____

Are you pregnant or breast-feeding_____ Type of birth control _____

Most recent mammogram and results _____ Most recent bone density and results _____

Have you ever been on testosterone replacement in the past? If yes, please explain _____

_____

New patient notice:

North Dallas Wellness Center has set aside 60 minutes for your first consultation with Dr. Fein. Unfortunately, the number of patient no-shows has increased, which prevents other patients from access to timely and convenient appointments. NDWC will request a credit card number to "hold" this hour-long time slot. Regrettably, in the event of a "no-show," a $100 fee will be charged.

PATIENT AGREEMENT FOR TREATMENT

North Dallas Wellness Center is an Insurance Free Entity.

IN CONSIDERATION of North Dallas Wellness Center and Physician(s) providing Patient with medical management, administrative, and follow-up services, Patient understands and agrees to the following:

Patient understands that North Dallas Wellness Center will not submit a claim to any third-party payor for any portion of the fee or services rendered, even if Patient is entitled to benefits. North Dallas Wellness Center does not accept assignment from any third-party payor as payment for services. Patient understands that Medicare, Medicaid, and Champus require a waiver that states Patient acknowledges the waiving of rights to seek reimbursement from these entities._____

MEDICAL HISTORY QUESTIONNAIRE: Patient agrees to submit an accurate and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate and complete information on this Questionnaire or to the Physician(s) of North Dallas Wellness Center could result in inappropriate treatment. _____

AUTHORIZATION: Patient authorizes NDWC to obtain, on Patient's behalf, medical laboratory, diagnostic testing, and/or compounding pharmacy supplies based on the Medical History Questionnaire and other information submitted to NDWC under this agreement. _____

INSTRUCTIONS AND TREATMENT: Patient agrees to comply with the instruction, treatment, and dosage schedules prescribed by Physician(s); to immediately cease any medical treatment prescribed by Physician(s) in the event of an adverse reaction arising from prescribed treatment; and to immediately notify NDWC and Physician(s) via phone call or email to *info@drdavidfein.com*. Patient understands and agrees that diagnosis and treatment of any medical condition may involve certain risk. _____

LABORATORY FEES: North Dallas Wellness Center will obtain laboratory testing from certified and registered labs in Texas, including LabCorp and QuestLab. Patient understands and agrees that Patient's insurance coverage may involve unexpected co-pays and/or deductibles, which may require patient to be financially responsible for those fees. _____

PRIMARY CARE PHYSICIAN: Patient represents that he or she is under the care of a Primary Care Physician, and that Patient will not rely on or substitute the advice of NDWC Physician(s) should it conflict with the advice of the Patient's PCP. _____

HORMONE REPLACEMENT THERAPY: Patient understands and agrees that, although each hormone has been approved by the FDA, the FDA only approves products made by pharmaceutical manufacturers. Therefore, the FDA does not approve or disapprove of hormones which are prescribed in compounded form or customized dose. Patient also understands that Physician(s) may choose to prescribe medications that are "off label" to offer the widest possible range of therapies. Off-label prescribing is a common and legal practice by many physicians whereby medications are prescribed for purposes other than originally approved._____

EMAIL COMMUNICATION: Patient understands and agrees that NDWC offers communications via email for matters such as lab results, appointment reminders, etc. Although NDWC has implemented reasonable technical safeguards, NDWC cannot guarantee privacy, security, or confidentiality of emails sent or received. NDWC is not responsible for emails that are lost due to technical failure during composition, transmission, or storage. NDWC will not forward emails to third parties without Patient's prior written consent, except as authorized or required by law. NDWC RESPECTS AND PROTECTS THE PRIVACY OF OUR PATIENTS. NDWC WILL NEVER SELL OR RENT YOUR EMAIL ADDRESS TO THIRD PARTIES. Patient may choose to discontinue receiving emails as a means of communication by sending an email or phone call to NDWC. _____

RESCHEDULING OR NO-SHOW: Unfortunately, the number of patient no-shows has increased, which prevents other patients from access to timely and convenient appointments. If Patient needs to reschedule or cancel appointment, he/she agrees to notify North Dallas Wellness Center within 24 hours of scheduled appointment. Patient understands that, regrettably, failure to do so may result in a $75 fee. _____

WARRANTY: Patient understands and agrees that the methods of medical treatment offered by NDWC and Physician(s) are not accompanied by any claims, guarantees, or warranties. _____

_____ _____

Patient Printed Name Patient Signature

_____

Date