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1715 N Westshore Blvd, Suite 100

Tampa, Florida 33607

Name:

Date of Birth: \_\_ Present Weight:

Address:

City: State: Zip:

Home phone: Cell:

Do you have an e-mail address that you can share with us?

Patient Employed By:

Business Address:

Business Phone:

Marital Status: (please circle) Married Divorced Single Widow Living w/Significant Other

Spouse’s Name: Phone:

In case of Emergency, whom should we notify?

Phone Number:

Would you like more information on our weight loss program? Yes/No

Would you like more information on our ageless cosmetics? Yes/No

Where did you hear about us?

🞎 Internet 🞎 T.V.

🞏 Tampa Health Care news 🞎 Radio

🞎 Friend / INFINITY Patient 🞎 Other:

Signature: Date:

**Hormonal Symptoms**

Please check all that apply:

\_\_\_\_ Sleep Disturbances – Are you taking medication for sleep? No Yes\*

\_\_\_\_ Fatigue

\_\_\_\_ Depression – Are you taking an antidepressant? No Yes\*

\_\_\_\_ Irritability

\_\_\_\_ Anxiety – Are you taking medication for anxiety? No Yes\*

\_\_\_\_ Mood Swings

\_\_\_\_ Weight Gain – How much? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_ High Cholesterol – Are you taking a cholesterol medication? No Yes\*

\_\_\_\_ Hair Loss

\_\_\_\_ Dry Skin

\_\_\_\_ No Sex Drive

\_\_\_\_ Painful Intercourse – Dry Vaginal Mucosa

\_\_\_\_ Erectile Dysfunction

\_\_\_\_ Poor Focus

\_\_\_\_ Memory Lapses

\_\_\_\_ Low Self Esteem

\_\_\_\_ Decreased Exercise Tolerance

\_\_\_\_ Loss of Muscle Tone

\_\_\_\_ Night Sweats

\_\_\_\_ Hot Flashes

\_\_\_\_ Body/Joint Pains

\_\_\_\_ Osteoporosis – Are you taking medication for osteoporosis? No Yes\*

\_\_\_\_ Fibromyalgia

\_\_\_\_ Chronic Fatigue Syndrome

\_\_\_\_ Restless Leg Syndrome

\_\_\_\_ Migraine Headaches

\_\_\_\_ Palpitations

\_\_\_\_ Diabetes – Are you taking medication for diabetes? No Yes\*

\_\_\_\_ High Blood Pressure – Are you taking medication for BP? No Yes\*

\_\_\_\_ Heart Disease – Are you taking medication for heart disease? No Yes\*

\* If you marked ‘Yes’, please list medications on the medication sheet.

**Medical History**

1. Do you have diabetes? No Yes
2. Do you have hypertension? No Yes
3. Do you have heart disease? No Yes
4. Do you have a heart murmur? No Yes
5. Do you have/had kidney disease No Yes
6. Have you ever been treated for psychiatric problems? No Yes
7. Have you had rheumatic fever? No Yes
8. Do you have mitral valve prolapsed? No Yes
9. Have you ever had a urinary tract infection? No Yes
10. Have you ever had hepatitis/liver disease? No Yes
11. Have you had varicosities/phlebitis? No Yes
12. Do you have thyroid problems? No Yes
13. Have you had any major accidents? No Yes
14. Have you had a blood transfusion? No Yes
15. Do you have asthma/lung disease? No Yes
16. Do you have Lupus? No Yes
17. Do you have arthritis? No Yes
18. Do you have any drug allergies? No Yes
19. Do you have diverticulitis? No Yes
20. Have you had a hysterectomy: No Yes
21. Please list any surgeries or hospitalizations:

1. Other medical history for yourself or family:

1. How many times have you been pregnant? Miscarriages?
2. Have you had any premature deliveries? No Yes
3. Are you sexually active? No Yes

**Medical History (continued)**

1. What type of contraception are you currently using? (circle below)

 Pills Tubal Ligation Condoms Withdrawal Depo Provera

 Foam Vasectomy Diaphragm Implants Other

1. Are you having problems with your method of birth control? No Yes
2. Date of last pap smear:
3. Have you ever had an abnormal pap smear? No Yes
4. Do you have trouble leaking urine? No Yes
5. Do you have any breast lumps, tenderness, or discharge? No Yes
6. Have you had a mammogram? No Yes

If yes, was it normal?

1. Have you used hormone replacement in the past? No Yes

 If yes, when?

1. Previous history of cancer? No Yes

 If yes, what type and when?

1. Family history of cancer? No Yes

 If yes, what type?

1. History of blood clotting problems or DVTS? No Yes
2. Family history of blood clotting problems or DVTs? No Yes
3. Do you have PMS symptoms? No Yes
4. Do you have uterine anomalies? No Yes

 If yes, explain:

1. If you no longer have periods, please state reason(s):
2. First day of last period?
3. How many days does your period last?
4. Are your periods regular? No Yes
5. How many days from the start of one period to the start of the next period?
6. Do you have bleeding between periods? No Yes
7. Do you have cramping with your period? No Yes

 If yes, circle one: Mild Moderate Severe

1. Do you smoke cigarettes: No Yes

If yes, # per day: How many years?

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| Date | Medication  | Dose/Strength  | Frequency |
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**HIPAA**

INFORMED CONSENT

 As of August 14, 2002, the government ruled that healthcare practices must be in compliance with HIPPA, a privacy ruling.

 To my patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created by Health Insurance Portability and Accountability Act of 1996.

 My commitment is to your privacy.

 My practice is dedicated to maintaining the privacy of your health information. I am required by law to maintain the confidentiality of your health information. I realize that these laws are complicated, but I must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances:

1. To public health authorities and health oversight agencies that are authorized by the law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. IF required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health or safety or the health or safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Rights Regarding your Health Information

1. Communications. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or payment to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You may submit your requests in writing.
4. You may ask to have your health care information amended if you believe it is incorrect, incomplete, and as long as the information is kept by or for this practice. To request an amendment, your request must be made in writing. You must provide a reason supporting your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with the board of Medical Examiners, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

If you have questions regarding this notice or health information privacy policies, please contact an INFINITY representative. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have been presented with a copy of the INFINITY Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

Signature

Print Patient Name

**If patient is a minor**

Print Patient Name

Parent/Guardian Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date