CENTER FOR PAIN RELIEF & LONGEVITY
WOMENS HISTORY FORM

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ CELL#: _____ HOME #: _____

DRIVERS LIC# (PA, OH, WV) _____ BIRTH DATE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

EMAIL ADDRESS: _____

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED

PATIENTS OCCUPATION: _____

OCCUPATION: _____ EMPLOYER: _____

HEIGHT _____FT _____ INCHES WEIGHT _____LBS

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____

CONTACT #: _____ ◯ CELL ◯ HOME

I am interested in discussing the following programs:

- ☐ Hormone Replacement Therapy
- ☐ Disc Problem
- ☐ Stem Cell Replacement Therapy
- ☐ Knee Pain
- ☐ Neuropathy
- ☐ Weight Loss
- ☐ Sexual Wellness
- ☐ Nutritional Counseling

Health History Questionnaire:

Primary Care Doctor (PCP): _____ Phone Number: _____

Personal Health History - Check all that apply.

General	☐ Diabetes	☐ High Cholesterol	☐ Unwanted Weight Loss
Cancer	☐ Personal History of Cancer (non-breast)	☐ Family History of Cancer (non-breast)	☐ Personal or Family History of Breast Cancer
Cardiovascular	☐ Heart Failure ☐ Vascular Disease ☐ Hypertension	☐ Heart Attack ☐ Blood Clots ☐ Irregular Heartbeat	☐ Heart Murmur ☐ Edema ☐ Congestive Heart Failure
Respiratory	☐ Sleep Apnea ☐ Bronchitis	☐ Shortness of Breath ☐ Pneumonia	☐ Asthma / COPD ☐ Allergies
Gastrointestinal	☐ Lactose Intolerance ☐ Chronic Diarrhea ☐ Blood in Urine	☐ Gall Bladder ☐ Chronic Constipation ☐ Kidney/Bladder History	☐ Gall Stones
Infection	☐ Kidney/Bladder	☐ Liver	
Psychiatric	☐ History of Depression	☐ Personality Disorder	

Do you or any of your family members have a history of Thyroid Cancer? ◯ Yes ◯ No

Do you have a history of Pancreatitis? ◯ Yes ◯ No

Date of your last annual exam / physical: _____

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers.

Drug Name: _____ Dosage: _____ Frequency: _____

Taken for _____

Drug Name: _____ Dosage: _____ Frequency: _____

Taken for _____

Drug Name: _____ Dosage: _____ Frequency: _____

Taken for _____

Allergies: ◯ Yes ◯ No If yes, list allergies and reaction

_____

_____

Surgeries:

Year_____ Surgery/Reason _____

Year_____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: ☐ None ☐ Mild ☐ Occasional vigorous exercise ☐ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____

_____

_____

Have you used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past? Please be completely truthful with your response, it is critical to diagnose and prescribe correctly.

_____

_____

Rate your quality of sleep: 1-Worst 10-Best

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

What is your ideal body weight? _____

What is the hardest part for you to lose weight? _____

What programs have your tried before to lose weight? _____

_____

How does being over weight effect you? _____

_____

What is your commitment level to losing weight?

1 2 3 4 5 6 7 8 9 10

Not committed Very Committed

Lifestyle Questionnaire

Alcohol: Yes Number of drinks per week: _____ No

Tobacco: Yes Cigarettes Cigars Chewing How many/much: _____ No

Illicit Drug Use: Yes, Explain _____ No

SYMPTOMS OF LOW HORMONE LEVELS

Decreased Concentration: Yes No

Difficulty learning new things: Yes No

Memory loss: Yes No

Moodiness: Yes No

Depression: Yes No

Increasing fatigue: Yes No

Decreasing energy: Yes No

Daytime sleepiness: Yes No

Breast Tenderness: Yes No

Hot Flashes: Yes No

Poor sleep habits: Yes No

Painful Intercourse: Yes No

I have had my hormone levels checked previously: Yes No

I have used hormones previously: Yes No

If yes, date(s): _____ Type: _____ Usage: _____

_____

I attest everything on this form is accurate. I understand that I am responsible for following the program. I give permission to the Center for Pain Relief & Longevity to communicate with me via telephone, text and email. If there are any questions or concerns, I am responsible to communicate that with the Center for Pain Relief & Longevity immediately.

Name: _____ Signature:_____ Date: _____

If you can't electronically sign above, Enter your name below

Signature _____

Patient Informed Consent for Weight-Management Medications with Center for Pain Relief & Longevity:

I,_____ authorize Center for Pain Relief to assist me in my weight-reduction efforts. I understand my treatment may involve, but is not necessarily limited to, the use of weight management medications by self-injection each week for 12 weeks or more and when indicated in higher doses than the dosage indicated in the medication's labeling. I have read and understand my doctor's statements that follow: "All prescription medication has labeling determined between its manufacturer and the U. S. Food and Drug Administration. This labeling contains among other things suggestions for use. Weight-management medication labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosage indicated on the label. I understand it is my responsibility to follow the instructions carefully and to report to the physician treating me for my weight any significant medical problems that I think may be related to my weight-control program, as soon as reasonably possible. Also, I will notify the physician of all medication I am taking, including anti-depressant medications and herbal supplements.

I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand that my continuing to receive the weight management medication will be dependent on my progress in weight reduction and weight maintenance. I understand the mechanism of action and how it is to be administered. I understand the administration of the medication will be performed via self subcutaneous injection and that alteration of prescribed plan or dosage may be harmful. I have been instructed in the use of the self-injection mechanism and I understand how to use it. I attest that I have not been diagnosed with thyroid cancer, family history of thyroid cancer, having any cancer, being pregnant, trying to get pregnant, ever having Medullary Thyroid Cancer or Multiple Endocrine Syndrome.

Risks of Proposed Treatment: I understand this authorization is given with the knowledge that the use of the weight management medication for 12-20 weeks and in higher dosages than those indicated on the label involves some risk and hazard. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common but more serious risks may include, Diabetic Retinopathy, injection site irritation, thyroid cancer, kidney injury, pancreatitis, hypoglycemia, GI related symptoms and other may be discussed depending on clinical presentation.

Alternatives to Proposed Treatment: Surgery, exercises, diet and supplements.

No Guarantees: I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue monitoring my weight all my life if I am to be successful.

Consent: 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 or any questions have not been answered to my complete satisfaction. I acknowledge that I have been given time to completely read and understand this form, as well as discuss with my physician the risks associated with the proposed treatment and other treatments not involving weight-management medications.

Patient Warning: If you have any questions as to the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, please ask your provider now before signing this consent form.

Patient's Name (print) _____ Date: _____

Patient's Signature _____

Physician Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the weight-management medications, the benefits and risks associated with alternative therapies, and the risks of obesity. After being adequately informed, the patient has consented to therapy involving the weight-management medications, if indicated, in the aforementioned manner.

Physician's Signature _____ Date _____