Health History Questionnaire

Date: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Email Address: _____

Referred by/How you heard about us: _____

Please note our 48 Hour Cancelation Policy: If you cancel or reschedule within 48 hours of your appointment or no show you will be charged a $75 fee.

Past Medical History

Reason for Today's Visit: _____

Please list past medical conditions: _____
_____
_____

Past surgeries: _____
_____
_____

Medication Allergies: _____
_____
_____

Current medications (with dose): _____
_____
_____
_____

Previous medications (no longer taking): _____
_____
_____

Supplements and vitamins used on a regular basis: _____
_____
_____

Family Medical History: _____
_____
_____
_____

Do you smoke? _____ How much? _____ Drink alcohol? _____ How much?____
Do you exercise? _____ How often? _____ Regular Basis ____ Seldom _____

Women Only

Are you Pregnant? _____Yes _____No
Do you plan to become pregnant within the next 12 months? _____ Yes _____ No
Date of last Menstrual period? _____ Date of Menopause? _____

ALLERGY HISTORY FORM

PATIENT NAME: _____ **DATE:** _____

PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS:

NASAL SYMPTOMS:	YES	NO
Sneezing	□	□
Colored/ thick nasal discharge	□	□
Throat Clearing	□	□
Itchy nose or throat	□	□
Sinus Infection	□	□
Bad breath	□	□
Nasal Congestion	□	□
Decrease in taste or smell	□	□
Snoring	□	□
Post-nasal drip	□	□
Sore throat	□	□
Mouth-breathing	□	□
Choking during sleep	□	□
Headaches	□	□
Nose bleeds	□	□

EYE SYMPTOMS:	YES	NO
Itching	□	□
Tearing Swelling	□	□
Burning	□	□
Black circles under eyes	□	□
Redness	□	□

CHEST SYMPTOMS:	YES	NO
Cough	□	□
Exercise intolerance	□	□
Chest tightness	□	□
Wheezing	□	□
Difficulty breathing	□	□
Shortness-of-breath	□	□

Are symptoms worse during certain months?
(Please place a checkmark in the appropriate box.)

	YES	NO
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Are your symptoms worse due to exposure to the following? *(Please place a checkmark in the appropriate box.)*

	YES	NO		YES	NO
Dust			Molds		
Trees			Dogs/Cat		
Grasses			Smoke		
Ragweed			Heat/ Humidity		

FOOD ALLERGIES:	YES	NO
Do any of the following foods cause mouth itching, throat closing: *Please circle specific food or write in:*		
Peanuts, Soy, Hazelnut	□	□
Fruits apples cherries peaches kiwi	□	□
Shellfish, Shrimp, Lobster, Crab	□	□
Bananas, Melons	□	□
Carrots, Celery, Potato	□	□
Other: _____	□	□

IMPORTANT QUESTIONS:	YES	NO
1. Have you missed work/ school due to your symptoms	□	□
2. Do you believe work exposure affects your symptoms	□	□
3. Commonly use over-the-counter medicine to treat allergies?	□	□
4. Commonly use prescription medication to treat allergies?	□	□
5. Do you have pets?	□	□
6. Does exposure to your pets make symptoms worse?	□	□
7. History of Asthma?	□	□
8. Do you take daily medications for control?	□	□
9. Been to ER or been hospitalized for breathing problems?	□	□
10. **Anaphylaxis** (severe allergic reaction) to a **medicine**, **food** or **insect sting**?	□	□
11. Are you currently on a beta-blocker? *Atenolol (Tenormin), Metoprolol (Lopressor, Toprol-XL) and Propranolol (Inderal)*	□	□
12. Are you pregnant?	□	□
13. Do you take immune suppressing drugs (cortisone, prednisone, or other) for arthritis, intestinal problems or cancer?	□	□

Please explain and "yes" answers: _____

_____

_____

_____

OCCUPATION:	YES	NO
Are you exposed to anything at work that may affect your symptoms?	□	□

Please list occupation: _____

_____
MD Reviewed

POLICIES AND PROCEDURES

In the interests of ensuring a smooth process for patient care, please review the following information:
To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the provider (please contact our office for details).

Office Hours – South Side Office

Monday	8:30 am – 4:00 pm
Tuesday	9:00 am – 4:30 pm
Wednesday	8:30 am – 4:00 pm
Thursday	8:30 am – 4:00 pm
Friday	9:30 am – 3:30 pm

Office Hours – Cranberry Office

Monday	8:30 am – 5:30 pm
Tuesday	10:00 am – 7:00 pm
Wednesday	8:30 am – 5:30 pm
Thursday	8:30 am – 5:30 pm
Friday	CLOSED

CANCELLATION POLICY: If a patient cancels or reschedules within 48 hours of the appointment or fails to keep the appointment, there will be a **$75 fee.**

PATIENT COMPLIANCE: All patients agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/appointment schedule.

SUBMITTING TO INSURANCE: Although The Hormone Center providers do not participate with any insurance programs patients receive itemized invoices with insurance claim codes for possible reimbursement. Since the providers have opted out of all **Medicare/Tricare** programs, **patients are NOT permitted to submit claims to any Medicare** or Tricare programs for reimbursement.

QUESTIONS FOR THE PROVIDERS: To ensure timely response, questions for all providers should be communicated through the registered nurse. Please email our nurse (elisabeth@hormonecenter.net) or call the office during regular office hours.

PRESCRIPTION REFILLS: Patients should first contact their pharmacist who will submit a request to our office. Allow 48 hours for all refill requests. You may request prescription refills through our office via email prescription@hormonecenter.net or phone. **Requests made after 1:00 p.m. on Friday will be reviewed on Monday.**

SUPPLEMENT ORDERS: Phone orders can be placed during regular office hours Monday through Friday. **Orders placed after 3:00 p.m. on Friday will be handled on Monday.**

I have read, understood and agree to abide by the above policies and procedures. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date

The Hormone Center
Skin Beautiful Medical Spa
How To Health

CONSENT FOR TREATMENT

I request treatment by The Hormone Center (THC), Skin Beautiful Medical Spa (SBMS) and/or How To Health ("HTH") physician or designee. I understand that I have the right, as a patient, to be informed about my condition and the recommended treatment to be used so that I can make an informed decision whether or not to undergo the treatment after I have been told both the potential benefits, risks, and hazards involved.

Some treatments used at THC/SBMS/HTH are considered "off label" use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. This practice is known as "off-label use" or "unlabeled uses". Such uses are not indicative of inappropriate usage but are legal and common. To access for information on off-label uses, please visit the FDA's website: www.fda.gov/eder

I agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the physician or her designee. I agree to immediately report any adverse reaction or problem to THC/SBMS/HTH.

I understand that the Providers at THC/SBMS/HTH, are not my Primary Care Provider (PCP). I understand that I will need a PCP to monitor any ongoing medical problems.

I understand that THC/SBMS/HTH does not accept insurance company payments for possible treatment nor does THC/SBMS/HTH coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility.

Although THC/SBMS/HTH are not subject to the Health Insurance Portability and Accountability Act (HIPAA), we follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at THC/ SBMS/HTH are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that THC/SBMS/HTH cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that any follow-up treatments required will be at my own expense. This consent form is valid until all or part is revoked in writing.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date Provider Signature Date

The Hormone center

2100 Wharton Street, Suite 315 – Pittsburgh, PA 15203
20399 Route 19, Suite 120 – Cranberry Twp. PA 16066
Phone: 412.432.7909 **Fax: 412.202.2304**

Payment, Blood Draw and Photo Consent Form

Patient Name: _____ **Date of Birth**: _____

PAYMENT POLICY

I understand that all fees are due at the time of service, unless otherwise specified by the provider.

I understand that there is a 48 hour cancellation policy that I will be charged $75 for either not showing for an appointment **or** for canceling/rescheduling an appointment within 48 hours of said appointment.

BLOOD DRAW CONSENT

In the instance that my provider is accidentally exposed to my bodily fluids (i.e., needle stick), I consent to have my blood drawn and tested for HIV and Hepatitis. The results of this testing will remain confidential as required by law.

PHOTOS

By checking one of the boxes below I give the provider permission to use my photographs in the following manner:

☐ **I only want my photos used in the medical chart**
The Hormone Center patients: this is only a face shot for our photo recognition program in our patient system.

☐ **I do not want any photos taken**
Medspa patients: I understand that by not having any photos taken I will not have documentation of before and after results of my treatment.

☐ **Unrestricted use of photographs**
This may include lectures, before and after pictures, website, etc.

COMMUNICATION VIA EMAIL AND/OR TEXT

By checking the boxes below I consent to communication/notification of the following:

☐ Medical information specific to my medical history, diagnosis, treatments and/or recommendations

☐ Appointment reminder

☐ Receive monthly specials for Skin Beautiful Medical Spa

For Email Notifications enter Email Address: _____@_____.____

For Text Notifications enter **CELL PHONE #**_____-_____-_____ ***Choose carrier below***
☐ Verizon ☐ AT&T ☐ Cingular ☐ Sprint ☐ T-Mobile

This consent form is valid until all or part is revoked in writing.

_____ _____ _____
Patient's Name **Signature** (Parent or Guardian if under 18) **Date**

PATIENT INFORMATION & CONSENT

_____ _____ _____

Last Name First Name Date of Birth

_____ _____

Address Apt #

_____ _____ _____

City State Zip Code

_____ _____ _____

Home # Work # Cell #

Name of emergency contact_____ Relationship_____ Phone _____

INSURANCE

Do you have: □ Medicare □Tricare □Neither

The providers have opted out of all **Medicare/Tricare** programs, patients are **NOT** permitted to submit claims to any Medicare/Tricare program for reimbursement.

If you answered checked Medicare or Tricare do you have a secondary insurance? ___Yes ___No

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HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that the physicians have a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that the physician or designee has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire.

☐ **I authorize the physician or designee to discuss my medical care and treatment with the following people (spouse, children, parent, etc.)**

1. _____ 2. _____
3. _____ 4. _____

I understand this form is valid until all or part is revoked in writing.

X_____ Date_____

The Hormone center

20399 Route 19 – Suite 120
Cranberry Twp., PA 16066

2100 Wharton Street – Suite 315
Pittsburgh, PA 15203

Naturopath Consent

I understand that I am here about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is considered a personal ministry and spiritual counseling. I understand that I am taking full responsibility for all decisions concerning my health and hereby release Jeanie Anderson N.D. and The Hormone Center in their service from any liability whatsoever.

I fully understand that Jeanie Anderson N.D. is not a medical doctor or practitioner and I am not here for medical-diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed by Jeanie Anderson N.D. is at all times restricted to the subject of nutrition matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

I understand that harmonic quads (zappers) have been demonstrated by research to kill some parasites, that zappers have not been approved by the AMA for use on humans, that no medical claims are made or implied by the manufacturer or by Jeanie Anderson and The Hormone Center in their services and that zappers should not be used by people with pacemakers or other electrical devices that may be implanted in the body.

_____

Printed Name

_____ _____

Signature **Date**