2100 Wharton Street-Suite 315, Pittsburgh, PA 15203
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Ph: 412-432-7909 Fax: 412-202-2304

OFFICE USE ONLY: ☐Dr. Loya ☐Dr. Hursh ☐J.Hook
Appt ___________ ☐Scanned ☐Entered

BIO-IDENTICAL QUESTIONNAIRE

Today's Date: ____________

Patient Information

Name: ________________________________ **Date of Birth:** ____________ **Age:** _______

Address: __________________________ **City:** ______________ **State:** ____ **Zip:** ______

Home Phone: __________________________ **Cell Phone:** _________________________

Email Address: ____

How did you hear about us:

☐ **Compound Pharmacy**_________________________ **and name of pharmacy employee** __________________

☐ **Current Patient** ______________________________ ☐ **Doctor** ____________________________________

☐ **Event/Seminar** _______________________________ ☐ **Hormone Center Employee** __________________

☐ **Internet/Web site** ____________________________ ☐ **Live/Work in Area**

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.

What are the top three symptoms/problems related to hormones you would like to see improved?

List them in order from Most Important to Least Important.

1____

2____

3____

Please score the two factors below on a scale from 1 - 10 (1=None 10=Significant)

1. **My energy Level** ______
2. **My sense of Well Being** ______

Please complete questionnaire with consent forms and return to the center at least 2 days before your appointment via email (info@hormonecenter.net), fax (412-202-2304) or mail.Past Medical History

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: __________________________________

____

____

- **How many hours do you sleep at night?** ___________________
- **Do you smoke?** ☐ Yes ☐ No **How much?** ___________
- **Drink alcohol?** ☐ Yes ☐ No **How much?** ___________
- **Do you exercise?** ☐ Yes ☐ No **How often?** ☐ Regular Basis ☐ Seldom
- **Date of most recent:** EKG _____ Stress Test_____ Lipid Panel _____

Bring results of most recent blood work within last year

- **Stress Level** (Please circle) High Moderate Low
- **List current stressors:** ____

____

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?** _________________
- **Date of last Pap smear?** ___________ **Completed by (Physician):**___________________
- **Date of last Mammogram?** __________ **Completed by (Physician):** __________________
- **Bone Density:** ____

Number of Pregnancies: ______________ **Number of Live births:** ______________ **Number of Miscarriages:** _____________	**Stress Level:** ____________________ **Stressors:** ____________________ ________________________________
PMS:____ **Vaginal Complaints:** ____	

Men Only

Date of last prostate exam? ___________ Completed by (Physician): _____________________

Date of last PSA test? ________________ Completed by (Physician):___________________

Family History

Uterine Cancer	(Y/N)	Who?	Age at Diagnosis?
Ovarian Cancer	(Y/N)	Who?	Age at Diagnosis?
Fibro Breast	(Y/N)	Who?	Age at Diagnosis?
Breast Cancer	(Y/N)	Who?	Age at Diagnosis?
Heart Disease	(Y/N)	Who?	Age at Diagnosis?
Osteoporosis	(Y/N)	Who?	Age at Diagnosis?
Colon Cancer	(Y/N)	Who?	Age at Diagnosis?
Thyroid Disorders	(Y/N)	Who?	Age at Diagnosis?

Symptom List

Some of these Symptoms are purposely repeated because different hormone deficiencies may result in similar symptoms

COR

Do you ever have the following symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much Or Often**	**Always or Extreme**
Poor tolerance to stress	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety with stress	[ ]	[ ]	[ ]	[ ]	[ ]
Low Blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Tired during day	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue or Mood improved with sugar/sweets	[ ]	[ ]	[ ]	[ ]	[ ]
Salt Cravings	[ ]	[ ]	[ ]	[ ]	[ ]
Nausea	[ ]	[ ]	[ ]	[ ]	[ ]
Inflammatory disease (arthritis, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Allergies to food or medications	[ ]	[ ]	[ ]	[ ]	[ ]
Brown spots or increased pigmentation	[ ]	[ ]	[ ]	[ ]	[ ]
Eczema, psoriasis or dandruff	[ ]	[ ]	[ ]	[ ]	[ ]
Sugar cravings	[ ]	[ ]	[ ]	[ ]	[ ]
Weak or tired when standing up	[ ]	[ ]	[ ]	[ ]	[ ]
Urinate often	[ ]	[ ]	[ ]	[ ]	[ ]
Low blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]

MEL

Do you ever have the following symptoms?	**No Symptom Never**	**Few or Sometimes**	**Moderate or Regularly**	**Much Or Often**	**Always or Extreme**
Poor sleep	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty falling asleep	[ ]	[ ]	[ ]	[ ]	[ ]
Awakening at night	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive pondering of problems at night	[ ]	[ ]	[ ]	[ ]	[ ]
Waking up tired (too little sleep)	[ ]	[ ]	[ ]	[ ]	[ ]

GH

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Thinning Hair	[ ]	[ ]	[ ]	[ ]	[ ]
Thinning Skin	[ ]	[ ]	[ ]	[ ]	[ ]
Longitudinal lines on nails	[ ]	[ ]	[ ]	[ ]	[ ]
Premature wrinkling on face	[ ]	[ ]	[ ]	[ ]	[ ]
Loose or sagging skin	[ ]	[ ]	[ ]	[ ]	[ ]
Thinning lips	[ ]	[ ]	[ ]	[ ]	[ ]
Overweight	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased muscle strength or tone	[ ]	[ ]	[ ]	[ ]	[ ]
Flabby muscles (Triceps of arm or	[ ]	[ ]	[ ]	[ ]	[ ]
other)	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkled hands	[ ]	[ ]	[ ]	[ ]	[ ]
Flabby dropping belly	[ ]	[ ]	[ ]	[ ]	[ ]
Often sick	[ ]	[ ]	[ ]	[ ]	[ ]
Easily exhausted	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to do daily required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Constant tiredness	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to stay up late	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to recover after staying up late	[ ]	[ ]	[ ]	[ ]	[ ]
Need for a lot of sleep (over 10 hours)	[ ]	[ ]	[ ]	[ ]	[ ]
Low resistance to stress	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to recover after stressful	[ ]	[ ]	[ ]	[ ]	[ ]
situation	[ ]	[ ]	[ ]	[ ]	[ ]
Not assertive	[ ]	[ ]	[ ]	[ ]	[ ]
Very emotional	[ ]	[ ]	[ ]	[ ]	[ ]
Mood Swings	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety	[ ]	[ ]	[ ]	[ ]	[ ]
Low self esteem	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Thin muscles as child	[ ]	[ ]	[ ]	[ ]	[ ]
Tendency to isolate	[ ]	[ ]	[ ]	[ ]	[ ]

Tend to give sharp verbal retorts	[ ]	[ ]	[ ]	[ ]	[ ]

THY

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Sensitive to cold	[ ]	[ ]	[ ]	[ ]	[ ]
Cold hands or feet	[ ]	[ ]	[ ]	[ ]	[ ]
Generalized fatigue	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue unless exercising	[ ]	[ ]	[ ]	[ ]	[ ]
Sleepy during day	[ ]	[ ]	[ ]	[ ]	[ ]
Distracted easily	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Headaches	[ ]	[ ]	[ ]	[ ]	[ ]
Water retention	[ ]	[ ]	[ ]	[ ]	[ ]
Constant swollen eyelids	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen eyes in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen calves/feet	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty losing weight despite dieting	[ ]	[ ]	[ ]	[ ]	[ ]
Constipation	[ ]	[ ]	[ ]	[ ]	[ ]
Bedwetting as a child	[ ]	[ ]	[ ]	[ ]	[ ]
Slow heart palpations	[ ]	[ ]	[ ]	[ ]	[ ]
Muscle cramps	[ ]	[ ]	[ ]	[ ]	[ ]
Carpal tunnel syndrome	[ ]	[ ]	[ ]	[ ]	[ ]
Stiff joints in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Joint pain worsens with cold	[ ]	[ ]	[ ]	[ ]	[ ]
Hoarse voice in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Dry skin (general/ feet or elbows)	[ ]	[ ]	[ ]	[ ]	[ ]
Slow growing or brittle nails	[ ]	[ ]	[ ]	[ ]	[ ]
Diffuse hair loss	[ ]	[ ]	[ ]	[ ]	[ ]
Muscle achiness or soreness	[ ]	[ ]	[ ]	[ ]	[ ]
Low body temperature	[ ]	[ ]	[ ]	[ ]	[ ]

Diminished sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Tingling or numbness in extremities	[ ]	[ ]	[ ]	[ ]	[ ]
Hoarse voice	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased hearing	[ ]	[ ]	[ ]	[ ]	[ ]
Course skin (rough skin)	[ ]	[ ]	[ ]	[ ]	[ ]

YEAST QUESTIONNAIRE

The total score for this section gives us the probability of yeast overgrowth being a significant factor in your case.

	Point Score
_____ Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?	50
_____ Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses over three times in a twelve-month period?	50
_____ Have you ever taken an antibiotic – even for a single course?	6
_____ Have you ever had prostatitis or vaginitis?	25
_____ Have you ever been pregnant?	5
_____ Have you taken birth control pills?	15
_____ Have you taken Corticosteroids such as Prednisone, Cortef, or Medrol?	15
_____ When you are exposed to perfumes, insecticides, or other odors or chemicals, do you experience wheezing, burning eyes, or any other distress?	15
_____ Are your symptoms worse on damp or humid days or in moldy places?	20
_____ Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat?	20
_____ Do you crave sugar or bread?	20
_____ Does tobacco smoke cause you discomfort (e.g. wheezing, burning eyes)?	10

Please add your points and record your Total Score ___________

Female Symptoms (TO BE COMPLETED BY FEMALES ONLY)

E

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Older looking than age	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of attention to details	[ ]	[ ]	[ ]	[ ]	[ ]
Bleeding gums or poor teeth	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue throughout the day	[ ]	[ ]	[ ]	[ ]	[ ]
Poor recovery from physical exercise	[ ]	[ ]	[ ]	[ ]	[ ]
Depressed	[ ]	[ ]	[ ]	[ ]	[ ]
Poor memory	[ ]	[ ]	[ ]	[ ]	[ ]
Hot flashes	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Dry eyes	[ ]	[ ]	[ ]	[ ]	[ ]
Dry vagina	[ ]	[ ]	[ ]	[ ]	[ ]
Pain during intercourse	[ ]	[ ]	[ ]	[ ]	[ ]
Pale skin	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkles around eye/forehead/mouth	[ ]	[ ]	[ ]	[ ]	[ ]
New body hair	[ ]	[ ]	[ ]	[ ]	[ ]
Dropping breasts	[ ]	[ ]	[ ]	[ ]	[ ]
Bladder infections	[ ]	[ ]	[ ]	[ ]	[ ]
Urinary incontinence	[ ]	[ ]	[ ]	[ ]	[ ]
First menstruation before 12 or after 15	[ ]	[ ]	[ ]	[ ]	[ ]
Depression before menstruation	[ ]	[ ]	[ ]	[ ]	[ ]

P

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Irritable before menstruation (PMS)	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen breasts/belly before menstruation	[ ]	[ ]	[ ]	[ ]	[ ]
Breast cysts	[ ]	[ ]	[ ]	[ ]	[ ]
Fibroids of uterus	[ ]	[ ]	[ ]	[ ]	[ ]
Endometriosis	[ ]	[ ]	[ ]	[ ]	[ ]
General irritability	[ ]	[ ]	[ ]	[ ]	[ ]
Generalized anxiety	[ ]	[ ]	[ ]	[ ]	[ ]

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
	[ ]	[ ]	[ ]	[ ]	[ ]
Too rigid	[ ]	[ ]	[ ]	[ ]	[ ]
Poor strength	[ ]	[ ]	[ ]	[ ]	[ ]
Low libido (sex drive)	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty achieving orgasm	[ ]	[ ]	[ ]	[ ]	[ ]
Poor muscle tone	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive fat	[ ]	[ ]	[ ]	[ ]	[ ]
Cellulite	[ ]	[ ]	[ ]	[ ]	[ ]
Varicose veins	[ ]	[ ]	[ ]	[ ]	[ ]
Hemorrhoids	[ ]	[ ]	[ ]	[ ]	[ ]
Bruising easily	[ ]	[ ]	[ ]	[ ]	[ ]

Male Symptoms (TO BE COMPLETED BY MALES ONLY)

T

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Older looking than age	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of feeling of well-being	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of attention to details	[ ]	[ ]	[ ]	[ ]	[ ]
Poorly motivated	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive fat	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of muscle mass or strength	[ ]	[ ]	[ ]	[ ]	[ ]
Poor recovery from physical activity	[ ]	[ ]	[ ]	[ ]	[ ]
Poor endurance	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Passive	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased memory	[ ]	[ ]	[ ]	[ ]	[ ]
Irritable	[ ]	[ ]	[ ]	[ ]	[ ]
Too emotional	[ ]	[ ]	[ ]	[ ]	[ ]
Rigid	[ ]	[ ]	[ ]	[ ]	[ ]
Hair loss	[ ]	[ ]	[ ]	[ ]	[ ]
Poor beard growth	[ ]	[ ]	[ ]	[ ]	[ ]
Scarce body hair	[ ]	[ ]	[ ]	[ ]	[ ]
Bleeding gums or poor teeth	[ ]	[ ]	[ ]	[ ]	[ ]
Dry eyes	[ ]	[ ]	[ ]	[ ]	[ ]
Pale skin	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkles on face/ palm of hand	[ ]	[ ]	[ ]	[ ]	[ ]
Poor endurance	[ ]	[ ]	[ ]	[ ]	[ ]
Varicose veins	[ ]	[ ]	[ ]	[ ]	[ ]
Hemorrhoids	[ ]	[ ]	[ ]	[ ]	[ ]
Easy bruising	[ ]	[ ]	[ ]	[ ]	[ ]
Poor wound healing	[ ]	[ ]	[ ]	[ ]	[ ]

Poor muscle tone (triceps or other)	[ ]	[ ]	[ ]	[ ]	[ ]
Joint pains	[ ]	[ ]	[ ]	[ ]	[ ]
Intense sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Urination problems	[ ]	[ ]	[ ]	[ ]	[ ]
Urinary incontinence	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of urine after urination	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen prostate	[ ]	[ ]	[ ]	[ ]	[ ]
Poor libido (sex drive)	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty achieving orgasm	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased ability to maintain erection	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased erections frequency of firmness	[ ]	[ ]	[ ]	[ ]	[ ]

POLICIES, PROCEDURES, & CONSENTS

Below is an explanation of our policies, procedures, and consent for treatment that will be followed as a patient in our practice. As a patient of our practice you must abide by all of our policies and procedures.

Please review each item:

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

- 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.

- 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. At times, this practice does recommend "off-label use" or "unlabeled uses" for medications. 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 serious adverse reaction or problem to THC/SBMS/HTH.

- I understand that misuse or the failure to follow treatment protocols as prescribed by THC/SBMS/HTH (noncompliance) can result in the dismissal of myself as a patient of the practice.

- I agree to update THC/SMBS/HTH with any demographic or medical health information in a timely manner to avoid disruption of care.

- I 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.

- 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).

- 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.

- To ensure timely response, questions for all provider between scheduled appointments should be communicated through the clinical staff by phone or through the patient portal.

- Medication refills will be processed in 48-72 business hours from the time of the request. At the time of the request please provide the name, dose, quantity, and pharmacy information to ensure a timely and efficient response.

- Refill requests made after Thursday at 1PM will be received on Monday as the office is closed on Fridays.

- 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. Patients will receive itemized invoices with insurance claim codes for possible reimbursement.

- Our providers have opted out of all Medicare/Tricare programs. Therefore, patients are NOT permitted to submit claims to any Medicare or Tricare programs for reimbursement.

- I give my consent for THC/SBMS/HTH to use my photographs for medical documentation/identification purposes.

- 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.

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

____

Relationship to Patient (if another than patient)

HIPAA - PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and discloser of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent.

The Patient Understands that:
• Protected health information may be disclosed or used for treatment, payment, or health
• The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice
• The Practice reserves the right to change the Notice of Privacy Practices.
• The patient has the right to restrict the use of their information but the Practice does not have to agree to the restrictions
• The patient may revoke this consent in writing at any time and all future disclosures will then cease
• The Practice may condition receipt of treatment upon the execution of this Consent.

I authorize THC/SBMS/HTH staff to discuss my medical care and treatment with the following people:

1.____ 2.____

3.____ 4.____

____
Printed Name: Patient or Representative

____ ____________________
Signature Date

____
Relationship to Patient (if another than patient)