FLORIDA CENTER FOR
HORMONES & WELLNESS

Welcome! *I am honored that you have chosen the Florida Center for Hormones and Wellness as your partner in your journey toward wellness. My team and I are committed to making your experience with us enjoyable, rewarding and beneficial to your overall health and well-being. I am sure that you will quickly see that my office is very different than most other medical offices in terms of the conditions we deal with, my treatment philosophy, my commitment to excellence and the time that we spend with our patients. Most importantly, I want you to feel that we are paying attention to your health and wellness needs and treating you as the most important member of the wellness team. Again, I am honored that you have chosen me as your wellness provider and I eagerly look forward to meeting you and helping you get started on your road to wellness.*

Sincerely,
John C Carrozzella, MD, MSMS

The Florida Center for Hormones and Wellness (FCHW) has established the following policies and procedures for the practice. By informing our patients of these policies, we believe that there will be fewer misunderstandings. Please read and sign where indicated. Please let us know if you have any questions.

NEW PATIENT PAPERWORK POLICY:

One thing that you will notice in my office is that I work very hard to run on time. It is our commitment that you do not sit in our waiting room; something that happens far too often in most other offices. To help me stay on schedule, **EITHER YOU MUST COMPLETE AND SEND YOUR PAPERWORK PRIOR TO YOUR APPOINTMENT OR YOU MUST SHOW UP AT LEAST 30 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME SO THAT YOU HAVE TIME TO COMPLETE YOUR PAPERWORK**. Out of respect for the patients that follow your appointment, if your paperwork is not complete by the time your appointment is scheduled to begin, my staff may be forced to re-schedule your appointment.

Please read and complete all the paperwork that pertains to your health history and all the forms that pertain to your demographic information, FCHW Policies and Procedures. Beyond those forms, at a minimum, please read and review all the consent forms so that you are familiar with their contents. This will allow you to formulate any questions that you might have. If you are comfortable signing them, go right ahead. If you want to discuss their contents, you will have plenty of opportunity to do so, either with my staff or with me. **Initial _____**

RETURNING THE PAPERWORK:

We ask that you fax or email the completed paperwork to the office 48 hours in advance of your visit. That way, we will be able to review your information and once you arrive, you will be ready to go. If for some reason you are unable to complete, please let us know. **Our fax number is: (407) 720-3521 and the direct email to our Patient Liaison is:** amanda@hormonesandwellness.com.

Initial _____

APPOINTMENT POLICY

In order to make your appointment run as efficiently as possible, it is best if you arrive at least 15 minutes early if your paper work has been filled out. If you need to complete your paperwork at the time of your visit you should arrive at least 30 minutes prior to your appointment to complete the necessary paperwork. Please notify us 24 hours before your scheduled appointment time if you want to cancel, change or reschedule your appointment. Failure to do so will result in a cancellation fee of $50. Arriving late for your appointment may result in rescheduling your appointment. **Initial _____**

FLORIDA CENTER FOR
HORMONES & WELLNESS

FINANCIAL POLICY

Payment is expected at the time of your visit. We will accept cash or most credit/debit cards. We do not accept checks.

Presently, we do not accept any insurances and are not contracted with any. We do not participate in the Medicare or the Medicaid programs. Payment for the full amount of the day's service is due at the time of service unless other arrangements are made. If the patient desires, we can provide a superbill for patient insurance filling. This office will not accept any assignment of benefits. Upon patient filing of claims, you should request that all payments be sent directly to you. Should any payment from the Insurance Company be received by this office, it will either be sent to the Insured or it will be returned to the Insurance Company. It is your responsibility to know all possible & potential outcomes for filling a claim.

Initial_____

Our financial office is available for consultations on payment plans. In the unlikely event that your account would be turned over to our collection agency due to non-compliance of payment plan agreements/seriously past due amounts, patients or guarantors will be responsible for all outstanding balances, regardless of the type of treatment, procedure or sale, in addition to a 25% collection fee charged to us by the collection agency. Future appointments cannot be scheduled until these balances are paid in full by cash or credit card. Accounts that are forwarded to our collection agency may be reported to the credit bureau and may impact your credit record/rating.

Reproduction of Medical Records: For patients and governmental agencies requesting copies of medical records, the fees charged shall be $1.00 per page for the first 25 pages and the $0.25 for each page thereafter. For all other entities, copying charges shall be $1.00 per page. Payment for reproduction shall be made in advance of the copies being produced. Postage for mailing may be an additional charge.

Letters, Forms and Special Reports: The fee for completion of simple forms and letters will be $25 per page. Special Reports will start at $100 and shall be charged commensurate with the work required to complete the report.

Initial_____

BLOODWORK:

If you need to have your blood work completed prior to your first visit, please make sure that you have it drawn at least 7 days in advance so that it will be completed by the lab prior to your arrival. Our office is able to draw blood for most labs, so if it is more convenient, you can always book a blood draw appointment in this office. Fasting is not necessary. If you are fasting, please make sure it is 8 hours prior to your appointment. There are countless insurance rules covering blood work. Unfortunately, my staff does not know them and cannot give you any advice as to what your co-payment or deductibles might be, so it is your responsibility to know exactly what your insurance will or will not cover.

Initial_____

If your Insurance does not cover the cost of your labs; if you have a high deductible or co-payment of if you just simply want to be completely "self-pay" we have arranged to have a very "low cost" cash price in the office. I have been able to get very favorable pricing from a private lab. This allows me to provide my patients a usual hormone evaluation panel for only $250. Many times, this price is even below the deductible on many Insurance Plans. If you would like to take advantage of that option, please contact our office at (407) 507-3837 to let us know you would like to take advantage of this option. The office is open M-Th from 9-5 and on Friday from 9-3. Notify the receptionist that you would like to schedule an appointment to have your blood work done and that you would like to take advantage of our low-priced labs.

Initial_____

FLORIDA CENTER FOR
HORMONES & WELLNESS

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACE OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information ('PHI'). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 15, 2013 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law.

We reserve the right make the changes in our privacy practices and the new terms of our effective Notice for all PHI that we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We may use and disclose your PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosers of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party or to other physicians who may be treating you. For example, we would disclose your PHI to other physicians in order to diagnose or treat you. In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g. specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associates involves the use or disclose of your PHI, we will have a written contact that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Marketing: We may use your PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your PHI to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public heath purposes.

Health Oversight: We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or of others. We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable state and federal laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an

individual.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

We may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You must make a request in writing to the primary practice location where you have most recently received service. You may also request access by sending us a letter to the address at the end of this notice.

Accounting for Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contacts us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make on such a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continue to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with an information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

FLORIDA CENTER FOR
HORMONES & WELLNESS

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact Person: Amanda Brown Florida Center for Hormones and Wellness
7575 Dr. Phillips Blvd – Suite 370; Orlando, FL 32819 (407) 507-3837

An electronic copy of this document shall carry the same weight as an original

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Florida Center for Hormones and Wellness's Policies and Procedures.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Personal Representative's Relationship to Patient: _____

Date: _____

Consent for Bio-identical Hormone Therapy in Women

Background:

You have been diagnosed with or have an increased risk of having a hormone deficiency(ies) and your doctor has recommended treatment with bio-identical hormone replacement therapy (BHRT). Many bio-Identical hormone preparations that include estrogen and progesterone are indeed approved for human use by the FDA, however some of the bio-identical hormone compounds that may be prescribed for you may or may not be regulated and or specifically approved by the FDA or by the pharmacy compounding law. The use of this therapy as it relates to your diagnosis, while common in Age Management, Wellness and other non-traditional medical practices, may be considered controversial in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard treatments to be used so that you make an informed decision whether or not to undergo the treatments after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may have the information needed to give or withhold your consent to the proposed treatment plan.

Possible alternative therapies might include the use of nutritional supplements or other hormonal therapies. Alternative therapies as such may lessen or eliminate the risks of hormone therapy, but these alternatives may or may not be as effective in the treatment of your condition. Of course, not taking the therapy is an alternative that may eliminate any risk of complications or side effects that are specifically related to the therapy. However, not taking the therapy will do nothing to reduce or eliminate any of the age-related disease risks that are attendant to any hormone imbalance

Informed Consent:

- I understand that this prescription for Hormonal Therapy is indicated for the treatment of the symptoms of Female Sex Hormone Deficiency, sometimes called Menopause, based upon my medical history, physical findings and laboratory tests.
- I understand that the treating health care provider cannot guarantee any positive results or that there will be no side effects or harm. The goal and potential benefit of this therapy is to prevent, reduce or control the symptomatic dysfunction that occurs as a result of hormone deficiency or the aging process and the low hormone production that occurs in aging females.
- Bio-identical hormone therapy is available in various forms including pills, capsules, sublingual drops, troches, topical creams, pellets and injection.
- I understand that the typical side effects associated with the use of estrogen and/or progesterone may include but are not limited to uterine bleeding, fluid retention, swelling of the ankles, breast and nipple tenderness, irritability, depression, headaches, aggravation of migraines, impaired glucose metabolism, and weight gain.
- I have been informed that estrogen or estrogen-progestin preparations have been given a “black box warning” by the FDA. I have also been informed that the treating health care provider, based upon his interpretation of the existing medical literature concerning bio-identical hormone therapy, strongly disagrees with the FDA “black Box” warning. The current text of the black box warning reads as follows:
- WARNING: ENDOMETRIAL CANCER, CARDIOVASCULAR DISORDERS, BREAST CANCER AND PROBABLE DEMENTIA
    - Estrogen-Alone Therapy:
        - There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens
        - Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia
        - The Women’s Health Initiative (WHI) estrogen-alone substudy reported increased risks of stroke and deep vein thrombosis (DVT)
        - The WHI Memory Study (WHIMS) estrogen-alone ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older

Initials MD: _____ / Pt: _____

John C Carrozzella
Florida Center for Hormones and Wellness
Orlando, Florida

Consent for Bio-identical Hormone Therapy in Women

- There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens
- Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia
- The Women's Health Initiative (WHI) estrogen-alone substudy reported increased risks of stroke and deep vein thrombosis (DVT)
- The WHI Memory Study (WHIMS) estrogen-alone ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older

- Estrogen Plus Progestin Therapy:
  - Estrogen plus progestin therapy should not be used for the prevention of cardiovascular disease or dementia
  - The WHI estrogen plus progestin substudy reported increased risks of stroke, DVT, pulmonary embolism (PE), and myocardial infarction (MI)
  - The WHI estrogen plus progestin substudy reported increased risks of invasive breast cancer
  - The WHIMS estrogen plus progestin ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older

- I have been advised by the treating health care provider that combination bio-identical estrogen and progesterone therapy has substantial medical literature in support of the improvement of women's health and longevity. It is the opinion of the treating heath care provider that the medical literature strongly contradicts the FDA "black box" warning. Specifically, there is medical evidence to suggest that combination bio-identical estrogen and progesterone therapy:
  - Reduces the risk of coronary artery and other cardiovascular diseases
  - Reduces the risk of osteoporosis and the risk of death from osteoporosis related fractures
  - Reduces the risk of age related dementias and Alzheimer's disease
  - Reduces the risk of macular degeneration
  - Reduces the risk of colon cancer and other certain female cancers
  - Reduces the risk of "all-cause mortality"; meaning that women who are hormone balanced live longer lives
  - Reduces the risk of or improves the symptoms of genital atrophy and sexual responsiveness
  - Reduces the effects of age related/hormone mediated psychogenic symptoms
  - Improves lipid metabolism
  - Improves Glucose/sugar metabolism and reduces the risk of type 2 diabetes
  - Provides a more beneficial hormonal environment for weight management
- Estrogen therapy may be but is not absolutely contraindicated in women with a history of the following: breast or uterine cancer, phlebitis, blood clots, bleeding problems, gall bladder disease, uterine fibroma, and liver disease. However, there is no conclusive medical evidence that bio-identical hormone therapy causes any of these serious health conditions.
- I understand that the typical side effects associated with the use of progesterone therapy may include but are not limited to breast and nipple tenderness, drowsiness, slight dizziness, water retention, anxiety, difficulty sleeping, depression, acne, rashes, hot flashes, appetite increases and weight gain.
- I have been advised that the FDA does not recognize an indication for the use of testosterone in women and that any such use would be considered "off label".

Initials MD: _____ / Pt: _____

John C Carrozzella
Florida Center for Hormones and Wellness
Orlando, Florida

Consent for Bio-identical Hormone Therapy in Women

- The FDA has issued several warnings governing the use of testosterone. These warnings have been issued regarding the use of testosterone in men, but have been "transferred" to the use of women, often without any medical evidence to support these advisories and warnings. The current warnings about testosterone include:
- TESTOSTERONE WARNINGS AND PRECAUTIONS:
    - Increase in the hemoglobin and hematocrit. Sometimes referred to (incorrectly) as Polycythemia.
    - Venous blood clots and thromboembolism
    - Cardiovascular risk
    - Hepatic (liver) risk
    - Edema
    - Sleep Apnea
    - Adverse change in lipid profile
    - Decrease in Thyroid Binding Globulin
- I have been advised by the treating health care provider that bio-identical testosterone therapy has substantial medical literature in support of the improvement of women's health and longevity. It is the opinion of the treating heath care provider that the medical literature strongly contradicts the FDA warnings about the use of testosterone in women and that there is medical evidence to suggest that bio-identical testosterone therapy:
    - Reduces the risk of coronary artery and other cardiovascular diseases
    - Reduces the risk of osteoporosis and the risk of death from osteoporosis related fractures
    - Reduces the risk of age related dementias and Alzheimer's disease
    - Reduces the risk of macular degeneration
    - Reduces the risk of breast cancer
    - Reduces the risk of colon cancer and other certain female cancers
    - Reduces the risk of "all-cause mortality"; meaning that women who are hormone balanced live longer lives
    - Reduces the risk of or improves the symptoms of genital atrophy and sexual responsiveness
    - Reduces the effects of age related/hormone mediated psychogenic symptoms
    - Improves libido and sex drive
    - Improves physical stamina, endurance and results of exercise
    - Improves muscle bulk and tone
    - Improves lipid metabolism
    - Improves Glucose/sugar metabolism and reduces the risk of type 2 diabetes
    - Provides a more beneficial hormonal environment for weight management
- TESTOSTERONE WARNING: SECONDARY EXPOSURE TO TESTOSTERONE
    - Virilization has been reported in children who were secondarily exposed to testosterone.
    - Children should avoid contact with unwashed or unclothed application sites in individuals using testosterone gel.
- I understand that the typical side effects associated with the use of testosterone may include but are not limited to oily skin, acne, moodiness, irritability, change in libido (most often an increase), hirsutism (facial hair growth) and scalp hair loss, hair growth where topical testosterone is applied, enlargement of the clitoris, voice changes (usually deepening), water retention, slight bruising or infection at the injection/pellet insertion site(if injection or pellet therapy is used), increased hematocrit in the blood count, alteration of lipid profile, changes in blood pressure, and insulin sensitivity changes.

Initials MD: _____ / Pt: _____

John C Carrozzella
Florida Center for Hormones and Wellness
Orlando, Florida

Consent for Bio-identical Hormone Therapy in Women

- I understand that smoking may substantially increase all risks associated with hormone replacement therapy and that it is an established medical fact that stopping smoking is an overall benefit to health and wellness.
- I agree to contact my provider and if necessary, seek immediate medical attention, in the event I knowingly develop any adverse side effects of any hormone therapy.
- I understand that the use of estrogen is still controversial in the traditional medical community. A lot of the negative feeling against estrogen replacement therapy arose from the Women's Health Initiative Study that was published by the National Institute of Health in 2002. The study did not evaluate bio-identical hormones; however, it did evaluate the effects of Premarin® (a horse urine derivative) and Provera® (a chemicalized, synthetic progestin). Among other things, the study found the following:
    - 41% more strokes (42 HRT VS 30 placebo in 10,000 person years)
    - 29% more heart attacks (37 HRT VS 30 placebo in 10,000 person years)
    - twice as many blood clots (34 VS 16 placebo in 10,000 person years)
    - 26% more breast cancer (38 VS 30 placebo in 10,000 person years)
    - 66% increase in Alzheimer's Dementia (45 HRT VS 22 in 10,000 person years)
    - 37% less colorectal cancer (0.63 relative risk reduction)
    - 33% fewer hip fractures (0.66 relative risk reduction)

  However, in multiple studies (one with over 80,000 women) completed since the WHI, the use of bio-identical hormones has shown no increase in cancer risk. In fact, some suggest a reduction in cancer risk when bio-identical estrogen and progesterone are properly balanced with each other and managed by a properly skilled physician. The bottom line is that bio-identical hormone replacement is intuitively safe in that it only replaces natural hormones to a physiological level that once was normal in the human body.
- Overall, it is the opinion of the health care provider that the risks of prolonged hormone imbalance in the aging years is far greater than any risk shown to be associated with the use of bio-identical hormone therapy. That is, the risks of illness and dying early is greater if treatment is withheld as opposed to initiating and continuing bio-identical hormone therapy through the aging years.
- I understand that when hormones are applied topically as a cream or a gel, they may transfer to others resulting in hormonal excess in those to whom the transference has occurred
- I understand the importance of maintaining a healthy lifestyle with the use of hormone replacement, and agree to continue with a recommended program of healthful nutrition, regular exercise, stress management and nutritional supplementation with the use of testosterone. I further agree to continue any other hormone replacement therapies recommended by my physician.
- The safe use of bio-identical hormone replacement therapy requires proper medical monitoring. To that end I understand that I will be required to undergo routine testing and medical screening as current medical standards indicate for the following:
    - Assessment for physical side effects 4-8 weeks after initial replacement and regularly thereafter.
    - Salivary or Blood hormone testing.
    - Other hormone levels may be monitored, as well as other blood tests ordered as appropriate for treatment.
    - PAP smears.
    - Mammograms.
    - DEXA – bone density scans.
    - Trans-vaginal Ultrasound evaluation as indicated.
    - Annually physical exam by your primary doctor and/or your OB/GYN

Initials MD: _____ / Pt: _____

John C Carrozzella
Florida Center for Hormones and Wellness
Orlando, Florida

Consent for Bio-identical Hormone Therapy in Women

Statement of Patient:

I understand that along with the benefits of any medical treatment or therapies, there are both potential risks and complications to treatment. Those risks and complications have been explained to me and I agree that I have received information regarding those risks, complications and benefits, and the nature of bio-identical and other hormone treatments and have had all my questions answered. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. By signing below, I agree and give my consent to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Wellness and Age Management physician, my primary care physician, or other specialist. I agree to see my primary care physician, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, GYN examinations, colonoscopy, EKG, etc. (as indicated). at least on a yearly basis.

I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I agree to testosterone therapy as described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient: _____ Date_____

Name (Print): _____

Statement of clinical educator: I have explained the therapy described above, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient has no further questions and wishes to initiate bio-identical hormone replacement therapy and the patient has verbalized to me his/her understanding of those risks and benefits he is giving verbal and written consent to initiate this therapy.

Name of Physician Explaining Procedures: _____ Date _____

Signature of Physician: _____

This consent is ongoing for this and all future BHRT Treatments.

Initials MD: _____ / Pt: _____

John C Carrozzella
Florida Center for Hormones and Wellness
Orlando, Florida

Consent for Thyroid Supplementation Therapy

Many individuals may have technically normal Thyroid levels, yet still they feel and experience many of the symptoms of low Thyroid, hypothyroidism or an underactive Thyroid. This may indicate that the Thyroid level for a particular individual is not adequate **for them**. In these instances, the use of Thyroid to treat symptoms and not blood levels may be considered an "off label" use of Thyroid hormone. This means that Thyroid hormone supplementation may be used in a manner or for a reason for which it is not specifically marketed. In essence, blood levels may be in the normal range, but those blood levels may not be optimal to maintain good health. In any particular case, Thyroid medication may be prescribed to alleviate SYMPTOMS and not necessarily to treat any specific Thyroid condition. And although weight gain may be a result of low Thyroid, increasing Thyroid level will not guarantee weight loss. Thyroid is not being prescribed specifically for weight loss.

Statement of Patient: I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment. There may also be certain risks of not being treated. The risks and potential complications of Thyroid supplementation most commonly seen (heart palpitations, headaches, anxiousness, tremors (shakiness), irritability, insomnia and sometimes diarrhea) have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of Thyroid supplementation and no promise or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Florida Center for Hormones and Wellness Provider. Giving Thyroid for symptoms is considered "off-label" use of the medication. I further understand that proper "optimization" levels of Thyroid may, at times, be much higher than what many other physicians consider "normal"

I acknowledge that it is my responsibility as the patient to comply and follow-up with getting my lab-work and following up with the lab results. If I have any symptoms such as heart palpitations, headaches, anxiousness, tremors (shakiness), irritability, insomnia or diarrhea, I agree to notify the office and follow-up for evaluation.

I agree to immediately report to my Provider any adverse reaction or problem that might be related to my therapy. Risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of Thyroid hormone treatments, and have had all my questions answered.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with Thyroid hormone replacement therapy. I acknowledge that I am NOT being given Thyroid for weight loss.

Name (PRINT) _____

Signature of Patient _____ **Date** _____

Statement of Provider: I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy. I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed the patient has no further questions and wishes to initiate Thyroid hormone replacement therapy.

Name of PROVIDER Explaining Procedures: _____

PROVIDER Signature _____

Florida Center for Hormones and Wellness

7575 Dr. Phillips Blvd – Suite 370
Orlando, FL 32819
(407) 507-3837

The Florida Center for Hormones and Wellness offers our patients communication via secure email and a secure patient portal. This form provides information about the risks of email, guidelines for email communication and how we will use email communication. It also will be used to document your consent for us to communicate with you by email.

Communication by email, even when sent securely, has a number of risks which include, but are not limited to, the following:

- Email can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of email may exist even after the sender or the recipient has deleted his/her copy.
- Email can be received by unintended recipients.
- Email can be intercepted, altered, forwarded or used without authorization or detection.
- Email senders can easily type in the wrong email address.
- Email can be used to introduce viruses into computer systems.
- Email may not conform to the requirements of Health Insurance Portability Act of 1996 ("**HIPAA**").
- Email does not allow us to guarantee that you have received or understand our response.

HOW WE WILL USE EMAIL: We will limit email correspondence to patients who are adults 18 years or older, or the legal representatives of patients. We will use email to communicate with you only about non-sensitive and non-urgent issues. All emails to or from you will be made a part of your medical record. You will have the same right of access to such emails as you do to the remainder of your medical file. Your email messages may be forwarded to another office staff member as necessary for appropriate handling. We will not disclose your emails to others unless allowed by state or federal law or with your written consent. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

_____ **Initial**

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL…CALL 911.

- Do not use email for **urgent problems**. If you have an urgent problem, call our office (407) 507-3837 or go to an urgent care facility.
- **Emails should not be time-sensitive.** While we try to respond to email messages daily, it may take up to three (3) working days or more for us to respond to your message.
- Urgent messages or needs should be relayed to us by using regular telephone communication.
- If you have not heard back from us within three days, call our office to follow up if we have received your email.

_____ **Initial**

GUIDELINES FOR EMAIL COMMUNICATION

1) When at all possible, use the patient portal to communicate with Florida Center for Hormones and Wellness.
2) Include the general topic of the message in the "subject" line of your email. For example, "advice," "prescription," "appointment" or "billing question."
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an email confirming receipt of our message after you have received and read an email message from us.
6) If your email requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your email.
7) Take precautions to protect the confidentiality of email, such as safeguarding your computer password and using screen savers.
8) Inform us of changes in your email address.

_____ **Initial**

Florida Center for Hormones and Wellness

7575 Dr. Phillips Blvd – Suite 370
Orlando, FL 32819
(407) 507-3837

CONSENT TO USE EMAIL COMMUNICATION

I, _____, am:
(print name)

_____ a) an established patient of Florida Center for Hormones and Wellness.

_____ b) the legal representative of an established patient,

I may want to communicate with Florida Center for Hormones and Wellness and the office staff by email. I understand the risks of communicating by email, in particular the privacy risks explained in this form. I understand that Email communication may not conform to the requirements of Health Insurance Portability Act of 1996 ("**HIPAA**") I understand that Florida Center for Hormones and Wellness cannot guarantee the security and confidentiality of email communication. Florida Center for Hormones and Wellness will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Florida Center for Hormones and Wellness by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Email should never be used to discuss any new issues or any sensitive medical information. Appointments should be made to discuss these issues.

I understand that Florida Center for Hormones and Wellness and/or his representative may use email to communicate with me for the purposes of providing educational material or regarding any products or services that Dr. Carrozzella feels are relevant to good patient care.

I understand that either I or Florida Center for Hormones and Wellness may stop using email as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising Florida Center for Hormones and Wellness in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for email communications to and from Florida Center for Hormones and Wellness.

An electronic copy of this document shall carry the same weight as an original.

_____ _____
(signature) (date)

_____ I decline / withdraw consent to use email as a communication tool

_____ _____
(signature) (date)

FLORIDA CENTER FOR
HORMONES & WELLNESS

Medicare Private Contract for Services from Physician who has Opted Out

This Private Contract is entered into by and between:
Patient Name or Legal Representative: _____
(each one referred to herein as "Patient") and **John Christy Carrozzella, MD** ("Doctor") pursuant to the Medicare requirements that relate to physicians who have opted out of Medicare. Doctor has filed the required Affidavit with Medicare within the time period required for this Private Contract to be effective.

1. Doctor's Obligations. Doctor hereby informs Patient of the following and agrees to undertake the following actions:

a. Doctor has not been excluded from participation in Medicare under §§1128, 1156 or 1892 of the Social Security Act. The decision to opt out of Medicare was a strictly voluntary one.

b. Doctor will make a copy of this Private Contract available to CMS upon its request.

c. The expected or actual effective date and the expiration date of the opt-out period to which this Private Contract applies are indefinite unless otherwise notified.

d. Doctor and Patient must enter into a new Private Contract for each opt-out period.

e. Doctor will provide a photocopy of this Private Contract to Patient or to Patient's legal representative before items or services are furnished to Patient under the terms of this Private contract.

f. Doctor will retain an original of this Private Contract with original signatures of both parties, for the duration of the opt-out period, although a scanned copy shall carry the same weight as the original.

2. Patient's Obligations. The Patient or the Patient's legal representative agrees to the following:

a. Patient accepts full responsibility for payment of Doctor's charge for all services furnished by Doctor.

b. Patient understands that Medicare limits do not apply to what Doctor may charge for items or services furnished to Patient by Doctor.

c. Patient agrees not to submit a claim to Medicare or to ask Doctor to submit a claim to Medicare.

d. Patient understands that Medicare payment will not be made for any items or services furnished by Doctor that would have otherwise been covered by Medicare if there was no Private Contract and a proper Medicare claim had been submitted.

e. Patient has entered into this Private Contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from a physician who has not opted out of Medicare, and that Patient is not compelled to enter into Private Contracts that apply to other Medicare-covered services furnished by other physicians who have not opted out.

f. Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

g. Patient entered into this Private Contract at a time when Patient did not require any emergency or urgent care services.

3. Controlling Law. The terms of this Private Contract shall be interpreted and controlled by applicable Medicare regulations, as amended from time to time. Both parties agree to comply with all such Medicare regulations and enter into such agreements as may be required from time to time by such regulations.

4. Patient Representative. If this Private Contract is being signed by a Patient Representative on Patient's behalf, the Patient Representative will provided Doctor with the documentation required to demonstrate that Patient Representative has the requisite legal authority to sign this Private Contract on Patient's behalf.

The parties have read and understood the provisions of this Private Contract and enter into this agreement freely and voluntarily.

Doctor:

_____

John Christy Carrozzella, MD

Date:

Patient/Patient Representative:

_____

Name:

Relationship to Patient:

Date:

An electronic copy of this document shall carry the same weight as an original.

FLORIDA CENTER FOR
HORMONES & WELLNESS

FEMALE INTAKE ASSESSMENT

First/Last Name _____

Date of Birth _____/_____/ _____

Address _____

City/State_____Zip Code_____

Phone: Home (___)_____Work (____)_____Cell (____)_____

Which phone number may we use to leave messages? O Home O Work O Cell O None

E-mail _____

Your Occupation_____Hours per week _____

Your Employer _____

Significant Other _____

Significant Other Occupation_____

Emergency Contact _____

Primary Care Physician_____Phone _____

Do you want us to send your notes to your PCP? O Yes O No

Insurance Provider _____

How did you hear about Florida Center for Hormones and Wellness? _____

Medical Information

Please bring copies of current (within past 2 years) medical reports and laboratory tests to your appointment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

Date of Last Primary Care Visit: _____Result: _____

Date of Last Gyn Exam: _____Result: _____

Date of Last PAP Smear: _____Result: _____

Have you ever had an abnormal PAP Smear? YES NO Explain: _____

Date of Last Mammogram: _____Result: _____

Date of Last Bone Density Test (DEXA SCAN): _____Result: _____

Have you Ever Been told that you Have Poly Cystic Ovarian Syndrome (PCOS): YES NO

Explain: _____

Have you ever been told you have a "sugar problem" or diabetes, even if it was during pregnancy? YES NO

Explain: _____

Are you sexually active? YES NO Comments: _____

Current Birth Control Method: NONE THE PILL IUD CONDOM MENOPAUSE Other: _____

If you have taken "The Pill", how many years? _____Year Started: _____Year Stopped: _____

Side effects of "The Pill": _____

Comments: _____

If you have used an IUD, when was it put in: _____ When was it take out: _____

Type of IUD: _____

Comments: _____

Do you have PMS (Pre-menstrual syndrome or any other problem with your Menstrual Cycle: YES NO

Describe:_____

_____

_____

_____

_____

At what age did you start your menstrual cycles? _____

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

Are you still having Menstrual Cycles? YES NO

Are they: REGULAR IRREGULAR HEAVY LIGHT CLOTS CRAMPS OTHER

Cycle: 27 Days 28 Days 29 Days 30 Days _____ Days

Comments: _____

Are you currently Pregnant: YES NO

Total number of pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Any pregnancy complications? _____

What Age / Year do you go into Menopause: Age: _____ Year: _____

Have you had a hysterectomy: YES NO If yes, did that take your ovaries as well: YES NO

If yes, why did you have a hysterectomy? _____

Have you ever used any type of hormone replacement? YES NO

If yes, please explain. List form of therapy (Cream, Pellet, Oral, Other) and dose if known

_____

_____

Doctor Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

List the top three reasons why you are here today for your consultation (Please answer. This Question is very important)

1._____

2._____

3._____

Please describe any other health concerns you might have. Also discuss and weight concerns you might have
PRINT AS MANY OF THESE PAGES AS NECESSARY

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

MEDICATIONS: List prescription and over-the-counter drugs you are currently taking or have previously taken for extended periods of time (greater than a month). Please bring your medications to your appointment.

Drugs Name	Reason for Taking	Dose (mg/day)	Date Started	Date Discontinued	Side Effects

Please list allergies to medications: _____

_____

_____

_____

Nutritional Supplements - Examples: Vitamin, minerals, herbal & Homeopathic remedies
For evaluation of content and quality please bring supplements to your appointment

Name /Type	Reason for Taking	Dose	Date Started	Results/Benefits

_____

_____

_____

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

Hospitalization, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure/Admission	Outcome/Results

Family History – Use the key below to identify family members and their associated health conditions. Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparents A: Aunt U: Uncle C: Child

Condition	Relative	Condition	Relative
Allergies		Eczema	
Alcoholism		Epilepsy	
Anemia		Gout	
Alzheimer's		Heart Disease	
Arthritis (Rheumatoid)		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Bleeding Disorder		Lupus	
Cancer ( )		Mental Disorder	
Cancer ( )		Nervous System Disease	
Celiac Disease		Obesity	
Cohn's Disease		Stroke	
Colitis		Thyroid (Hypo/Hyper)	
Depression		Other ( )	
Diabetes Type 1		Other ( )	
Diabetes Type 2		Other ( )	

Dr. John C. Carrozzella, M.D.
Florida Center for Hormones & Wellness 7575 Dr. Phillips Blvd., Suite 370, Orlando FL
phone (407) 507.3837 fax (407) 720-3521

FLORIDA CENTER FOR
HORMONES & WELLNESS

Personal Habits – Substance Use

	Tobacco	Alcohol	Caffeine	Drugs
Currently Use				
Previously Used				
Never Used				
How much/many per day/week/month				
Specify Type: (cigarettes/cigars/ pipe/chewing tobacco; beer/wine/ spirits; tea/coffee/espresso/soft drinks/ energy drinks/ weight loss products; cocaine/marijuana/ heroin/ ecstasy)				
Duration of use (month/years)				
Date Quit				

Exercise (Complete this section only if you exercise regularly)

Type of exercise (biking, walking, yoga, jogging, weights, swimming)	**How long per session** (minutes, hours)	**Frequency** (daily, weekly)	**How long have you been doing this specific activity?** (week, month, years)

Female Hormone Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

	Symptoms	Not at all	A Little	Some	Quite a bit	Extreme
1	**Depressive Mood** (feeling down/sad/lack of drive)					
2	**Memory Loss** (forgetfulness)					
3	**Mental confusion** (feeling in a mental fog)					
4	**Difficulty in concentrating**					
5	**Anxiety** (feeling tense or nervous)					
6	**Feeling tense or nervous**					
7	**Feeling tired or lacking in energy**					
8	**Loss of interest in most things**					
9	**Feeling unhappy or depressed**					
10	**Mood changes/Irritability**					
11	**Migraine/Severe headaches**					
12	**Sleep problems** (difficult to fall/stay asleep/wake up tired)					
13	**Bloating**					
14	**Weight Gain**					
15	**Decreased sex drive/libido** (decreased desire for sex)					
16	**Difficult to climax sexuall**(decreased sexual responsiveness)					
17	**Breast tenderness**					
18	**Vaginal dryness**					
19	**Hot flashes**					
20	**Night sweats**					
	Row Total					
	OVERALL TOTAL					

Name: _____

Date: _____

Thyroid Hormone Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

	Thyroid Symptoms	Not at all	A Little	Some	Quite a bit	Extreme
1	**Weight gain**					
2	**Chronic constipation**					
3	**Feeling cold (especially hands and feet) even on warm days**					
4	**Fatigue, exhaustion and low energy throughout the day**					
5	**Slowness of thought processes (brain fog)**					
6	**Indecisiveness**					
7	**Poor memory and concentration**					
8	**Sluggishness**					
9	**Muscle weakness**					
10	**Pain and stiffness in muscles or joints**					
11	**Depression, mood swings and severe PMS**					
12	**Thick, dry, coarse skin**					
13	**Creviced, cracking skin on heels, elbows and knee caps**					
14	**High cholesterol**					
15	**Menstrual cycle irregularities (prolonged and heavy)**					
16	**Infertility**					
17	**Numbness and tingling (especially in hands and face)**					
18	**Brittle hair and nails**					
19	**Hair loss**					
20	**Headaches or migraines**					
21	**Low Blood pressure problems**					
22	**Reduced libido**					
23	**Stiff neck and shoulders**					
23	**Eye brow thinning (outer third)**					
24	**Irritability**					
25	**Fluid Retention**					
	Hypo-thyroid row total					
	HYPO-THYROID TOTAL					
	Hyper-Thyroid Symptoms					
1	**Heart palpitatons / High heart rate** (do you feel your heart beeting out of your chest)					
2	**Irritability / Restlessness**					
3	**Tremors / Shakiness**					
4	**Anxiety**					
5	**Diarrhea**					
6	**Feeling of being overheated / Excessive sweatiness**					
7	**Can't sleep / Insomnia**					
8	**Itching and hives**					
9	**Mental and emotional disturbances**					
10	**Hair Loss**					
	Hyper-thyroid row total					
	HYPER-THYROID TOTAL					

Name: _____

Date: _____

Cardiovascular Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

1	**Gender**	Female	Male
2	**Race**		
3	**Do you have a known heart condition?**	YES	NO
4	**Are you overweight?**	YES	NO
5	**Do you exercise regularly?**	YES	NO
6	**Do you smoke?**	YES	NO
	Did you ever smoke?	YES	NO
7	**If yes, how many packs a day?**		ppd
8	**If yes, how long ago did you quit?**		
9	**Are you being treated for or do you have High Blood Pressure?**	YES	NO
10	**Do you have a sugar metabolism problem, insulin resistance, metabolic syndrome or diabetes?**	YES	NO
11	**Do you have a high cholesterol problem?**	YES	NO
12	**If yes, what is your untreated Total Cholesterol?**		mg/dl
13	**If yes, what is your untreated Total Cholesterol?**		mg/dl
14	**If yes, do you take a statin for cholesterol?**	YES	NO
15	**Family History of Heart Attack?**	YES	NO
16	**Family History of Angina (chest pain with exertion)?**	YES	NO
17	**Family History of Stroke?**	YES	NO
18	**Family History of Diabetes?**	YES	NO

Doctor Notes:

Name: _____

Date: _____

Female Sexual Function Index Questionnaire (19Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

These questions ask about the effects that your erection problems have had on your sex life over the last four weeks. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

sexual activity includes intercourse, caressing, foreplay & masturbation

sexual intercourse is defined as sexual penetration of your partner

sexual stimulation includes situation such as foreplay, erotic pictures etc.

orgasm is the fulfilment or climax following sexual stimulation or intercourse

1	**Over the past 4 weeks, how *often* did you feel sexual desire or interest?**	1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
2	**Over the past 4 weeks, how would you rate your *level* (degree) of sexual desire or interest?**	1 - Very low or none at all 2 - Low 3 - Moderate 4 - High 5 - Very high	Answer in this Box
3	**Over the past 4 weeks, how *often* did you feel sexually aroused ("turned on") during sexual activity or intercourse?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
4	**Over the past 4 weeks, how would you rate your *level* of sexual arousal ("turn on") during sexual activity or intercourse?**	0 - No sexual activity 1 - Very low or none at all 2 - Low 3 - Moderate 4 - High 5 - Very high	Answer in this Box
5	**Over the past 4 weeks, how *confident* were you about becoming sexually aroused during sexual activity or intercourse?**	0 - No sexual activity 1 - Very low or no confidence 2 - Low confidence 3 - Moderate confidence 4 - High confidence 5 - Very high confidence	Answer in this Box
6	**Over the past 4 weeks, how *often* have you been satisfied with your arousal (excitement) during sexual activity or intercourse?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box

Name: _____

Date: _____

Female Sexual Function Index Questionnaire (19Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

7	**Over the past 4 weeks, how *often* did you become lubricated ("wet") during sexual activity or intercourse?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
8	**Over the past 4 weeks, how *difficult* was it to become lubricated ("wet") during sexual activity or intercourse?**	0 - No sexual activity 1 - Extremely difficult or impossible 2 - Very difficult 3 - Difficult 4 - Slightly difficult 5 - Not difficult	Answer in this Box
9	**Over the past 4 weeks, how often did you *maintain* your lubrication ("wetness") until completion of sexual activity or intercourse?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
10	**Over the past 4 weeks, how *difficult* was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?**	0 - No sexual activity 1 - Extremely difficult or impossible 2 - Very difficult 3 - Difficult 4 - Slightly difficult 5 - Not difficult	Answer in this Box
11	**Over the past 4 weeks, when you had sexual stimulation or intercourse, how *often* did you reach orgasm (climax)?**	0 - No sexual activity 1 - Almost never or never 2 - A few times (less than half the time) 3 - Sometimes (about half the time) 4 - Most times (more than half the time) 5 - Almost always or always	Answer in this Box
12	**Over the past 4 weeks, when you had sexual stimulation or intercourse, how *difficult* was it for you to reach orgasm (climax)?**	0 - No sexual activity 1 - Extremely difficult or impossible 2 - Very difficult 3 - Difficult 4 - Slightly difficult 5 - Not difficult	Answer in this Box
13	**Over the past 4 weeks, how *satisfied* were you with your ability to reach orgasm (climax) during sexual activity or intercourse?**	0 - No sexual activity 1 - Very dissatisfied 2 - Moderately dissatisfied 3 - Equally satisfied & dissatisfied 4 - Moderately satisfied 5 - Very satisfied	Answer in this Box

Name: _____

Date: _____

Female Sexual Function Index Questionnaire (19Q-LF)

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

14 **Over the past 4 weeks, how *satisfied* have you been with the amount of emotional closeness during sexual activity between you and your partner?**

0 - No sexual activity
1 - Very dissatisfied
2 - Moderately dissatisfied
3 - Equally satisfied & dissatisfied
4 - Moderately satisfied
5 - Very satisfied

Answer in this Box

15 **Over the past 4 weeks, how *satisfied* have you been with your sexual relationship with your partner?**

1 - Very dissatisfied
2 - Moderately dissatisfied
3 - Equally satisfied & dissatisfied
4 - Moderately satisfied
5 - Very satisfied

Answer in this Box

16 **Over the past 4 weeks, how *satisfied* have you been with your overall sexual life?**

1 - Very dissatisfied
2 - Moderately dissatisfied
3 - Equally satisfied & dissatisfied
4 - Moderately satisfied
5 - Very satisfied

Answer in this Box

17 **Over the past 4 weeks, how *often* did you experience discomfort or pain during vaginal penetration?**

0 - Did not attempt intercourse
1 - Almost always or always
2 - Most times (more than half the time)
3 - Sometimes (about half the time)
4 - A few times (less than half the time)
5 - Almost never or never

Answer in this Box

18 **Over the past 4 weeks, how *often* did you experience discomfort or pain following vaginal penetration?**

0 - Did not attempt intercourse
1 - Almost always or always
2 - Most times (more than half the time)
3 - Sometimes (about half the time)
4 - A few times (less than half the time)
5 - Almost never or never

Answer in this Box

19 **Over the past 4 weeks, how would you rate your *level* (degree) of discomfort or pain during or following vaginal penetration?**

0 - Did not attempt intercourse
1 - Very high
2 - High
3 - Moderate
4 - Low
5 - Very low or none at all

Answer in this Box

	Raw Score	Factor	**Score**	Min Score	Max Score
Desire (1,2)		0.6		1.2	6.0
Arousal (3, 4, 5, 6)		0.3		0.0	6.0
Lubrication (7, 8, 9, 10)		0.3		0.0	6.0
Orgasm (11, 12, 13)		0.4		0.0	6.0
Satisfaction (14, 15, 16)		0.4		0.8	6.0
Pain (17, 18, 19)		0.4		0.0	6.0

Name: _____

Date: _____

Pelvic Health Questionnaire

This questionnaire will help the doctor determine your diagnosis and best treatment plan
Please answer EVERY question to the best of your ability

1	***Have you ever experienced any of the following:***		
2	**A general sense of looseness (laxity) in the vaginal area?**	YES	NO
3	**Feeling of looseness during intercourse?**	YES	NO
4	**Feeling that the vaginal area is not as firm or as tight as it once was?**	YES	NO
5	**Tampons slipping?**	YES	NO
6	**Urine leakage especially when coughing, sneezing, jumping, etc.?**	YES	NO
7	**Disrupted sleep due to frequent rrips to the bathroom?**	YES	NO
8	**Painful intercourse due to dryness?**	YES	NO
9	***How would you rate your current level of vaginal tone?*** ***(circle one)***		
10	Loose Moderately Loose Slightly Loose Neither Loose or Tight		
11	Slightly Tight Moderately Tight Tight Don't Know		
12	**Has this changed over time?**	YES	NO
13	***Has a feeling of looseness affected your:***		
14	**Self confidence?**	YES	NO
15	**Sexual self image?**	YES	NO
16	**Interest in having sex?**	YES	NO
17	**Intimacy with your partner?**	YES	NO
18	**Overall sexual enjoyment?**	YES	NO
19	**Ability to engage in day-to-day activites?**	YES	NO
20	**Sense of control over your bladder?**	YES	NO
21	**Sense of control over bodily changes?**	YES	NO

Anything Else?

Name: _____

Date: _____