Patient Registration

First Name: _____Last Name: _____ MI:_____

Birth Date: ____/____/_____Gender: ____M/____F

Address:_____

City: _____State: _____Zip Code:_____

E-mail Address: _____

Home Phone: (_____) _____

Occupation: _____

Cell Phone: (_____) _____

Can we leave a message on your voicemail? Employer: _____

Yes No

Marital Status: ____S____M____D____W Name of Spouse: _____

Spouse Phone: _____ Spouse Employer: _____

Please tell us how you heard about us: Internet _____ T.V. _____ Radio _____Other(specify)_____

If referred please tell us by whom so that we may thank them: _____

Consultations and all office visits are **exempt and not covered by any insurance carriers.** I acknowledge and understand that I am financially responsible for all services rendered to me at the conclusion of the visit.

Patient Signature: _____Date: _____

Medical History for Lifestyle Spectrum

Name: _____ Date: _____

Past Medical History (Do you currently have or ever had any of the following):

- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Heart Disease
- ☐ Thyroid Disorder
- ☐ GERD/Reflux
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Anemia
- ☐ Cancer (Type/Location)_____
- ☐ Arthritis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Osteoporosis/Osteopenia
- ☐ Depression
- ☐ Anxiety
- ☐ Kidney Disease

Are you pregnant, planning to become pregnant, or nursing? ☐ Yes ☐ No

List other medical conditions: _____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

_____

Surgeries:

_____

_____

_____

Supplements:

_____

_____

_____

Medication Allergies:

_____

Tobacco Use: Age started: ___Amount per day: ___Age quit: ____Currently using amount ___per day/ week

Alcohol Use: Number of drinks per day ____or per week _____or per month _____or Rare/ Never _____

MENSTRUAL HISTORY

1. Are your periods regular? ☐YES ☐NO

2. If you no longer have periods, please circle reason:

Surgery Natural menopause

If other, please state reason: _____

3. How many days do your periods last? _____

4. Has the flow changed in any way? _____If so, how? _____

5. Do you have any bleeding between periods? ☐YES ☐NO

6. Do you have any cramping with your periods? ☐YES ☐NO

If yes, circle one: mild moderate severe

GYN HISTORY

1. Are you using any type of contraception? (CIRCLE BELOW)

Pills Tubal Ligation Condoms Depo Provera IUD

Foam Vasectomy Diaphragm Implants Other _____

2. What type of contraception have you <u>used in the past?</u> (CIRCLE BELOW)

Pills Tubal Ligation Condoms Depo Provera IUD

Foam Vasectomy Diaphragm Implants Other _____

3. Are you having any problems with your method of Birth Control? ☐YES ☐NO

4. Have you ever had any vaginal, cervical and/or tubal infection? ☐YES ☐NO

If yes, please check below:

☐Yeast ☐Gardnerella ☐Syphllis ☐Condyloma ☐Bacterial Vaginitis ☐PID

☐Herpes ☐Trichomonas ☐Chlamydia ☐Gonorrhea ☐Warts ☐Other _____

5. Have you ever had an abnormal pap smear? ☐YES ☐NO

If yes, How was it treated?

☐Repeated Pap Smear ☐Colposcopy ☐Laser Surgery ☐Cone Biopsy

☐Cryosurgery (freezing) ☐Hysterectomy ☐Loop Excision

6. Have you had cervical cancer? ☐YES ☐NO

If yes, how was it treated? _____

7. Have you had uterine cancer? ☐YES ☐NO

If yes, how was it treated? _____

8. Have you had ovarian cancer? ☐YES ☐NO

If yes, how was it treated? _____

9. Do you have any breast lumps, tenderness or discharge? ☐YES ☐NO

10. Have you had a mammogram? ☐YES ☐NO

If yes, was it normal? ☐YES ☐NO

Date of last mammogram _____

11. Do you do breast self exams? ☐YES ☐NO

12. Do you have PMS symptoms? ☐YES ☐NO

If yes, any treatment?_____

13. Do you have a history of infertility? ☐YES ☐NO

14. Do you have fibroids of the uterus? ☐YES ☐NO

15. Have you had abnormal bleeding in the past year? ☐YES ☐NO

If yes, please describe:_____

SYMPTOM CHECKLIST

Do you have:

Night sweats	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Hot flashes/hot flushes	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Pain with intercourse	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Vaginal dryness	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Sleeping problems	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Urine leaks when you cough or sneeze	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Difficulty concentrating/memory loss	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Mood swings	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Migraines	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Depression	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Anxiety	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Decrease in sexual desire	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Decrease in energy level	☐ Frequently	☐ Moderate	☐ Rarely	☐ No
Weight Gain	☐ Yes	☐ No		

Other Symptoms:

_____

_____

_____

_____

_____

CONSENT FOR HORMONE SUPPLEMENTATION THERAPY

General Bio-identical hormones are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone which are made in the ovaries and adrenal gland. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

I request and consent to the administration of hormones and authorize that these will be prescribed by Dr. Frank Comstock, MD. I acknowledge that there are no guarantees or assurances made with respect to the benefits of hormone supplementation therapy prescribed to me.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reactions or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

Benefits and Risks The potential benefits of testosterone include a possible increase in bone density, short term memory, protection against Alzheimer's, increase in energy, libido, and sense of well-being. I may also see testosterone decreasing the frequency and severity of my headaches. The potential benefits of estradiol include possible elimination of my mood swings, anxiety and irritability, cardiovascular protection and protection from developing colon cancer and brain dysfunction.

Side effects or complications are substantially more rare than in the case of non‒bioidentical hormones, but may include: Breast tenderness and swelling especially in the first few weeks after starting estrogen, water retention, weight gain. I also realize the estradiol can aggravate fibroids or polyps, if they exist, and cause uterine bleeding.

Bioidentical testosterone therapy can contribute to acne, facial hair growth, and loss of hair in a minority of patients due to the conversion of testosterone to DHT. Rare but reversible side effects of testosterone therapy include change in voice and clitoral enlargement. In the past, male athletes have abused testosterone. When they took huge quantities of synthetic testosterone, they may have incurred heart problems and elevated cholesterol. However, low-dose, non-oral, natural testosterone has not been associated with these problems.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the physician is for hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies including Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

My signature below certifies that I have read and understood the above and my acknowledgement that I have been encouraged to ask any questions regarding my hormone therapy and all my questions have been answered to my satisfaction.

_____ _____

Patient Signature(FEMALE) Date

_____ _____

Physician Signature Date

Women Release of Medical Records Consent Form

****Please complete and send to your physician PRIOR to your upcoming appointment.**

****It is important for Lifestyle Spectrum and Dr. Frank Comstock to have your current pap and mammogram report.**

To: Date:_____

_____
Your Doctor's Name

_____
Address

_____

_____
Phone Number & Fax

I, _____authorize_____
(Your Name) (Your Doctor's Name)

to release any and all information from the **last 2 years only**:

- Mammogram Report Only
- Pap Report
- Bone Density
- Ultrasounds
- Endometrial Biopsy
- Any Current Hormone Labs

***WE DO NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!

To:

Lifestyle Spectrum Frank Comstock M.D.
6127 N. La Cholla Blvd
Suite 175
Tucson, AZ 85741
520.547.2820---Voice
520.547.2822---Fax

_____ _____
Patient Signature Patient Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

According to HIPAA and Governmental rules all patients are asked to sign this release form. This notifies the office that you understand we follow all HIPAA rules by acknowledging this information sheet.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to receive and use this information:

☐ Insurance Company

☐ Pharmacy (Release of name, date of birth, allergies only)

☐ Significant Other or Family Member: _____

☐ Physician: _____

Information that may be used/disclosed:

- Record of visits (all)
- History & Physical
- Progress Notes
- Lab Reports
- Medication Records
- Consultation Reports
- Problem List
- Statement of Charges/Payments

1. I understand that my health care will not be affected if I do not sign this form.

2. I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

3. **I UNDERSTAND THIS IS NOT IN RELATION TO REQUESTING MEDICAL RECORDS FOR MYSELF OR ANOTHER DOCTOR. THERE IS A SEPARATE FORM THAT IS FILLED OUT FOR THAT REQUEST WHICH I CAN OBTAIN BY CONTACTING THE MEDICAL RECORDS DEPARTMENT.**

_____ _____

Signature of Patient or Representative Today's Date

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Lifestyle Spectrum, L.L.C. Notice of Privacy Practices.

_____

Name

_____

Signature

_____

Date

Do you give us permission for you to receive our services and product information by e-mail?

□ Yes □ No

Do you give us permission to remind you by telephone of an appointment at home or at work?

□ Yes □ No

If yes please write phone number you prefer _____

This acknowledgement page should be retained by patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

_____

_____

_____

_____

_____