

Patient Registration

First Name: _____ Last Name: _____ MI: _____

Birth Date: ___/___/_____ Gender: ___M/___F

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Occupation: _____

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):

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease |

(Type/Location) _____

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 used in the past? (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 Syphilis Condyloma Bacterial Vaginitis PID
 Herpes Trichomonas Chlamydia Gonorrhea Warts Other _____

GYN HISTORY CONTINUED

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

If yes, How was it treated?

- | | | | |
|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Repeated Pap Smear | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Cone Biopsy |
| <input type="checkbox"/> Cryosurgery (freezing) | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> 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 | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Hot flashes/hot flushes | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Pain with intercourse | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Vaginal dryness | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Sleeping problems | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Urine leaks when you cough or sneeze | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Difficulty concentrating/memory loss | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Mood swings | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Migraines | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Depression | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Anxiety | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Decrease in sexual desire | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Decrease in energy level | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Moderate | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | No |
| Weight Gain | <input type="checkbox"/> | Yes | <input type="checkbox"/> | 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.

