**Virtue Anti-Aging Female**

**Raffi Krikorian M.D.**

**Rachael Nicholson FNP**

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|  | **Personal Data** |  |
| Name | Date | Social Security # |
| Address | City State | Zip |
| Home phone | Work phone/Cell phone | Date of birth |
| Employer | Emergency Contact | Phone |
| Email | Marital Status  Married Single |  |
|  | **Primary Care Physician** |  |
| Name | Phone/Fax Number |  |
| Address | City State | Zip |
| Pharmacy Name | Phone/Fax Number |  |

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| **Present Symptoms** |
| Please briefly describe your symptoms. |
| What do you feel is the most important factor to your present symptoms? |

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|  | **Past Surgical History** |
| Date | Surgery |
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| **Past Medical History** | |
| Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates. | |
| Date | Medical diagnosis, illness, accident |
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| **Medications:** Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.** | | |
| Name of Medication | Dosage | Dosing schedule |
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| **Allergies**  Are you allergic to any MEDICATIONS (Prescription or OTC) |
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| **Family History** | | |
| Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known. | | |
| **Relationship** | **Age** | **Medical Problem(s)/ Cause of Death** |
| Mother |  |  |
| Father |  |  |
| Brothers |  |  |
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| Sisters |  |  |
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| Children |  |  |
| Spouse |  |  |

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| **Social History** |
| Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints |
| Do you smoke cigarettes now or have you in the past? Yes No   * If yes, how many packs per day? \_\_\_\_\_\_\_\_ * How many total years have you smoked? \_\_\_\_\_\_\_\_   Do you drink alcohol? Yes No   * If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? Yes No   * If yes, what substance(s) and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Gynecological History** | | |
| Date of last PAP smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician who performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility where performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | YES | NO |
| Have you ever had an abnormal PAP smear? If yes, what was the  abnormality and what follow up did you have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you ever had an abnormal mammogram? If yes, what was the  abnormality and what follow up did you have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you ever had a breast biopsy? |  |  |
| Have you ever had a cervical biopsy? |  |  |
| Have you noticed breast skin or nipple changes? |  |  |
| Have you noticed any lumps in your breasts? |  |  |
| Are you using a birth control method? If yes, what kind?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Are you still having menstrual periods? If yes, when was the first day of  Your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Please describe any problems you have with your periods:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Periods are (were): regular irregular painful crampy heavy light other | | |
| Age periods began: \_\_\_\_\_ # days of bleeding \_\_\_\_\_ cycle length (days) \_\_\_\_\_ | | |
| If you are no longer having periods, at what age did your periods stop? \_\_\_\_\_  If your periods stopped less than one year ago, how many months ago was your last period? \_\_\_\_\_ | | |
| Did your periods stop because you had a hysterectomy? Yes No   * If yes, what was the reason for the surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Were the ovaries removed at the same time? Yes No Not Sure | | |
| Do you have a history of any of the following cancers:  Vulva Ovary Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Uterus Fallopian Tube  Vagina Breast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cervix Colon | | |

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| **Hormone Therapy History** | | | | |
| Have you been treated with any hormone replacement therapy? If yes, please give approximate  Periods of treatment: | | | | |
| Hormone | Dose | Reason | Start Date | Stop Date |
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| **Estrogens**  Check which of these symptoms are troublesome and have persisted over time | |
| **Estrogen Deficiency** | **Estrogen Excess / Progesterone Deficiency** |
| Hot Flashes  Night Sweats  Vaginal Dryness  Foggy Thinking  Memory Lapses  Urinary Incontinence  Tearful  Depressed  Sleep Disturbances  Heart Palpitations/Arrhythmia  Bone Loss  Headaches | Mood Swings (PMS) Uterine Fibroids  Cystic Ovaries Weight Gain – Hip Area  Tender Breasts Bleeding Changes  Heavy Menses Elevated Triglycerides  Water Retention Breast Cancer  Sugar Craving Low Libido  Nervousness  Irritable  Anxious  Fibrocystic Breast  Headaches  Cold Body Temperature |

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| **Androgens**  Check which of these symptoms are troublesome and have persisted over time | |
| **Androgen Excess** | **Androgen Deficiency** |
| Increased Facial Hair  Increased Body Hair  Acne  Oily Skin  Nervous  Irritable  Anxious  Breast Cancer  Ovarian Cysts  Elevated Triglycerides  Sleep Disturbances | Low Libido Heart Palpitations/Arrhythmia  Vaginal Dryness Headaches  Fatigue. Fibromyalgia  Aches/Pains . Irritable  Memory Lapses Thinning Skin  Foggy Thinking Bone Loss  Urinary Incontinence  Depressed  Anxious  Sleep Disturbances  Apathy/Decreased Passion for Life  Decreased Muscle Mass |

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| **Adrenals**  Check which of these symptoms are troublesome and have persisted over time | |
| **Cortisol Excess** | **Cortisol Deficiency** |
| Sleep Disturbances Heart Palpitation/Arrhythmia  Bone Loss Headaches  Fatigue Stress  Weight Gain – Waist Nervousness  Loss of Muscle Mass Sugar Cravings  Thinning Skin Low Libido  Elevated Triglycerides Hair Loss  Breast Cancer Increased Facial Hair  Irritable Increased Body Hair  Anxious Acne  Memory Lapses | Exhaustion/Fatigue  Sugar Craving  Allergies  Chemical Sensitivity  Stress  Apathy/Decreased Passion for Life  Irritable  Arthritis  Heart Palpitations  Aches/Pains  Cold Body Temperature |

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| **Thyroid**  Check which of these symptoms are troublesome and have persisted over time | |
| **Thyroid Excess** | **Thyroid Deficiency** |
| Heat Intolerance  Irritable  Heart Palpitations/Arrhythmia  Weight Loss  Tremors/Shakiness  Diarrhea  Nervousness/Anxious/Panic Attacks  Insomnia  Difficulty Conceiving/Infertility | Cold Intolerance Aches/Pains  Constipation Hair Loss  Fatigued/Weakness Muscle Weakness  Unexplained Weight Gain Muscle Cramps  Inability to Lose Weight  Stress  Cold Body Temperature  Coarse Dry Skin  Lack of Motivation  Voice has become hoarse |

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| **System Review** – Check the appropriate box for each question. | | | |
| **Constitutional / ID / Oncology** | **Yes** | **No** | **Not Sure** |
| Have you had unexplained weight loss? |  |  |  |
| Do you have fever and chills? |  |  |  |
| Do you have night sweats? |  |  |  |
| Do you notice swollen lymph nodes? |  |  |  |
| Have you ever been diagnosed with cancer? |  |  |  |
| Have you ever tested positive for HIV? |  |  |  |
| Have you ever had a sexually transmitted disease? |  |  |  |
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| **Respiratory** |  |  |  |
| Do you have a persistent cough? |  |  |  |
| Do you have recurrent sinus infections? |  |  |  |
| Do you have excessive daytime sleepiness? |  |  |  |
| Do you snore? |  |  |  |
| Have you ever been diagnosed with asthma or emphysema? |  |  |  |

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| **System Review** – Check the appropriate box for each question. | | | |
| **Cardiovascular** | **Yes** | **No** | **Not Sure** |
| Do you have chest pain? |  |  |  |
| Do you have palpitations? |  |  |  |
| Do you have shortness of breath? |  |  |  |
| Do you have swelling in your legs? |  |  |  |
| Do you have leg pain while walking? |  |  |  |
| Vascular disease or artery blockages/aneurysms? |  |  |  |
| Have you been diagnosed with any heart condition?  Have you ever been diagnosed with a blood clot? |  |  |  |
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| **Gastrointestinal** |  |  |  |
| Do you have problems swallowing food? |  |  |  |
| Do you have nausea or vomiting? |  |  |  |
| Do you have diarrhea? |  |  |  |
| Do you have blood in your stool? |  |  |  |
| Do you have abdominal pain or swelling? |  |  |  |
| Have you ever been diagnosed with hepatitis or liver disease? |  |  | |
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| **Endocrine** |  |  |  |
| Do you urinate frequently or in larger amounts than usual? |  |  |  |
| Do you have greater than normal urge to eat? |  |  |  |
| Do you have elevated blood sugar? Diabetes? |  |  |  |
| Are you excessively thirsty? |  |  |  |
| Do you have facial hair? |  |  |  |
| Do you have acne? |  |  |  |
| Have you ever been diagnosed with a thyroid problem? |  |  |  |
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| **Neurological** |  |  |  |
| Do you have muscle weakness? |  |  |  |
| Have you ever had a seizure? |  |  |  |
| Have you ever fainted? |  |  |  |
| Have you experienced double vision or blind spots? |  |  |  |
| Have you ever been diagnosed with a stroke? |  |  |  |
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| **Urologic / Renal** |  |  |  |
| Do you have burning when you urinate? |  |  |  |
| Do you have urgency when you urinate? |  |  |  |
| Do you urinate more frequently than others? |  |  |  |
| Do you leak urine when laughing or coughing? |  |  |  |
| Have you ever had any kidney problems? |  |  |  |

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| Physician Notes: | | | | |
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| Patient Name | | Date | | |
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| Reason for Visit | | Type of Visit  Initial Follow-Up Final | | |
| **Tests Ordered or Received** | | | | |
|  | Ordered | | Received | |
| CBC |  | |  | |
| Skin Tests |  | |  | |
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| PFT |  | |  | |
| Radiology |  | |  | |
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| Request Medical Records Yes | | | | |
| Review of Records: | | | | |
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| **Subjective Data (Symptoms/Content)** | | | | |
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| **Objective Data (Observation/Labs)** | | | | |
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| **Assessment/Diagnosis or Impression** | | | | **Code** |
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| **Plan / Medications** | | | | |
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| Follow-Up Days Weeks Months PRN | | | | |
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| Signature Time In Time Out  AM PM AM PM  Total Time:\_\_\_\_\_\_\_\_\_ | | | | |

**Disclosure / Liability Waiver**

**VIP Aesthetics, LLC – Bio-Identical Hormone Replacement Program**

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from [Name of Practice]. its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

**Maintenance of Preventative Medicine and Cancer Surveillance**

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, mammogram, prostate examination, and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

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Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date