Inspire Medical Weight Loss & Wellness

Name:_____ Date:_____

Height: _____ Weight: _____ Blood Pressure:_____

Medical History:_____

Family Medical History: (Heart Disease, HBP, Cholesterol, Diabetes, Cancer (Type):

_____

Allergies: _____

Hobbies: _____

Occupation: _____

Hysterectomy: Y or N Reason: _____ Do you still have Ovaries: Y or N

Pregnant: Y or N Are planning on becoming pregnant: Y or N Breastfeeding: Y or N

First Day of Last Period: _____ How many days does your cycle last: _____
Bleeding between Cycles: Y or N Cramping: Mild, Moderate or Severe
Are your periods regular? Y or N Last Mammogram: _____ Normal: Y or N
Breast Tenderness: Y or N Last PAP: _____ Normal: Y or N

What Type of Contraception are you currently using:
( ) Menopause ( ) Tubal Ligation ( ) Pills ( ) IUD ( ) Condoms ( ) Other :_____

Alcohol / Tobacco / Recreational Drug use: _____ How much: _____

Please check ANY of the following health conditions:

		( ) Mastectomy
( ) Diabetes	( ) Metabolic Disorder	( ) PCOS (Polycystic Ovarian Syndrome)
( ) Hypoglycemia	( ) Kidney Disease	( ) Metabolic Disorder
( ) Stroke	( ) Heart Disease/ Bypass	( ) Auto Immune Disorder/ Lupus
( ) Hormone Imbalance	( ) Hormone Cancer	( ) Thyroid Imbalance/ Hashimoto's
( ) Drug Addiction	( ) Metabolic Disorder	( ) Liver Disease (fatty liver/ cirrhosis)
( ) High Blood Pressure	( ) Depression/ Anxiety	( ) Blot Clots/ Pulmonary emboli
( ) Uterine Fibroids	( ) High Cholesterol	( ) Seizure/ Epilepsy Disorder
( ) Anorexia	( ) Bulimia	( ) Cancer (type) _____

Please list any health conditions NOT mentioned: _____
If checked any of the above please explain: _____

Do you currently have or been have you been diagnosed with a hormonal cancer such as uterine or breast cancer? YES or NO If yes have you been tested for BRCA I, BRCA II or HERS? What was the treatment?

_____

Do you have a 1st degree family member who has been diagnosed or treated for hormone cancer such as uterine or breast? Have they been tested for BRCA I, BRCA II or HERS? What was treatment?

_____

Please list ALL medications you are currently taking INCLUDING SUPPLEMENTS:

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

Are you currently taking a Probiotic? Y or N Are you currently taking fish oils? (Omega 3's) Y or N

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**

NAME (print): _____ TODAYS DATE: ___/_____/_____

What are your CURRENT symptoms?

0 means you have NO SYMPTOMS / 5 would be MODERATE / 10 would be SEVERE

Progesterone		
Sleep Disturbances	0 1 2 3 4 5 6 7 8 9 10	_____
Depression	0 1 2 3 4 5 6 7 8 9 10	_____
Irritability	0 1 2 3 4 5 6 7 8 9 10	_____
Anxiety	0 1 2 3 4 5 6 7 8 9 10	_____
Mood Swings	0 1 2 3 4 5 6 7 8 9 10	_____
Migraine Headaches	0 1 2 3 4 5 6 7 8 9 10	_____
Estrogen		
Painful Intercourse (Female)	0 1 2 3 4 5 6 7 8 9 10	_____
Hot Flashes	0 1 2 3 4 5 6 7 8 9 10	_____
Thyroid		
Fatigue	0 1 2 3 4 5 6 7 8 9 10	_____
Dry Skin	0 1 2 3 4 5 6 7 8 9 10	_____
Brittle Nails	0 1 2 3 4 5 6 7 8 9 10	_____
Inability to Lose Weight	0 1 2 3 4 5 6 7 8 9 10	_____
Thinning/Brittle Hair	0 1 2 3 4 5 6 7 8 9 10	_____
Hair Loss	0 1 2 3 4 5 6 7 8 9 10	_____
Cold all the time	0 1 2 3 4 5 6 7 8 9 10	_____
Weight Gain	0 1 2 3 4 5 6 7 8 9 10	_____
Constipation	0 1 2 3 4 5 6 7 8 9 10	_____
Testosterone		_____
Loss of Muscle Tone	0 1 2 3 4 5 6 7 8 9 10	_____
Night Sweats	0 1 2 3 4 5 6 7 8 9 10	_____
Low Sex Drive	0 1 2 3 4 5 6 7 8 9 10	_____
Lack of Energy	0 1 2 3 4 5 6 7 8 9 10	_____
Weight Gain	0 1 2 3 4 5 6 7 8 9 10	_____
Poor Focus	0 1 2 3 4 5 6 7 8 9 10	_____
Joint Pain	0 1 2 3 4 5 6 7 8 9 10	_____
Memory Lapse	0 1 2 3 4 5 6 7 8 9 10	_____
Erectile Dysfunction (Male)	0 1 2 3 4 5 6 7 8 9 10	_____
First Day of Period: (Female)	_____	

HIPAA Form

Introduction

At **Inspire Medical & Wellness**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which **Inspire Medical & Wellness** is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures **Inspire Medical & Wellness** may contact patients with appointment reminders, requests for the patient to contact **Inspire Medical & Wellness** for appointments, notices and letters concerning medical findings. **Inspire Medical & Wellness** may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

Individual Rights

Although your health record is the physical property of **Inspire Medical & Wellness**, the information belongs to you. You have the right to:

1 The right to request restrictions on certain uses and disclosures of your information;
2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3 The right to receive confidential communications;
4 The right to obtain a copy or inspect your health information;
5 The right to amend protected health information;
6 The right to receive an accounting of disclosures of protected health information.

Inspire Medical & Wellness Center's Rights

1. **Inspire Medical & Wellness** has 30 days with which to comply with a patient's request to review or copy their health information. **Inspire Medical & Wellness** is allowed an additional 30 days if the record is off site. **Inspire Medical & Wellness** may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. **Inspire Medical & Wellness** will charge staff time for this service.

Inspire Medical & Wellness Center's Duties

1. **Inspire Medical & Wellness** is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. **Inspire Medical & Wellness** is required to abide by the terms of this Notice; and
3. **Inspire Medical & Wellness** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201. Further Information-Please contact the SMC administrator at 747-5861 for further information. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____Date of Birth:_____
Signature:_____Date:_____
Witness Signature (Check In)_____Date:_____