New Patient Questionnaire

Today's Date:_____

First Name: Last Name: Email:

_____ _____ _____

Street Address: City: State: Zip:

_____

Home Phone: Work Phone: Cell Phone: Date of Birth:

_____ _____ _____ _____

Age: Height: Weight: Gender:

_____ _____ _____ M F

How did you hear about us? _____ If referred by someone, who? _____

Are you interested in any of the following: (Please Circle all that apply)

Aesthetics (i.e. Botox, Juvéderm, Facials, Skin Care) Body Sculpting (Laser treatments)

Men's Sexual Wellness Weight Loss Hormones

If your goal is to lose **WEIGHT**- Please answer the following questions honestly, so we can do our best to help you reach your goals.

If not please skip to next page.

On a scale of 1-10, how important is it that you get to your goal weight? _____

What are the 3 MOST important reasons for WHY you desire to lose weight permanently?

1._____ 2._____ 3._____

Desired weight? _____ Desired weight loss amount? _____

Would you commit to one visit a week? Yes No

Have you attended any other weight loss centers/programs and, if so, which ones? _____

Over the past 10 years, has your weight remained the same, been better, gotten worse? _____

Have you had blood work in the last 6 months? Yes No If so, where? _____

Have you been advised by your primary care physician to lose weight? Yes No

If yes, what is your doctor's name and phone number? _____

Preferred Pharmacy name, city and phone number? _____

Does your family support your weight loss efforts? Yes No

Are you an emotional eater? Yes No If you answered yes, please explain: _____

_____

Inspire Medical Weight Loss & Wellness

Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure (if known): _____

Medical History: _____

_____

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

_____

_____

Allergies: _____

Occupation: _____ Hobbies: _____

Alcohol/Tobacco/Recreational Drug Use: _____ How much and how often? _____

Please circle ANY of the following health conditions:

Diabetes	Metabolic Disorder	PCOS	Stroke
Hypoglycemia	Kidney Disease	Heart Disease/Bypass	Autoimmune/Lupus
Hormone Imbalance	Thyroid/Hashimoto's	Drug Addiction	Liver Disease
High Blood Pressure	Depression/Anxiety	Blood Clots/Pulmonary Emboli	Uterine Fibroids
High Cholesterol	Seizures/Epilepsy	Anorexia/Bulimia	Cancer(type)_____

Please list any health conditions NOT mentioned: _____

Female only please complete below:

Hysterectomy: Yes No Reason: _____ Do you still have your ovaries? Yes No

Pregnant: Yes No Are you planning on becoming pregnant: Yes No Breastfeeding? Yes No

If menstruating, first day of last period _____ How long is your period? _____

Bleeding between cycles: Yes No Cramping: None Mild Moderate Severe

Are your periods regular? Yes No Breast Tenderness: Yes No

Last PAP: _____ Normal: Yes No

Last mammogram: _____ Normal: Yes No

Bone Density Test: Yes No

What type of contraception are you currently using:

Pill IUD Condoms Tubal Ligation Menopause Other: _____

Do you currently or have you been diagnosed with a hormonal cancer, such as uterine or breast? Yes No

If yes, please provide oncologist name and phone number: _____

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? Yes No

Please list ALL medications you are currently taking, including supplements and vitamins:

Name:	Dose:	How often:	Reasons:	Prescribing Doctor:

Are you currently taking a probiotic? Yes No

Are you currently taking a fish oil/Omega 3? Yes No

Are you currently on Hormone Replacement Therapy? Yes No If so, what type? _____

Previous Hormone Replacement Therapy? Yes No If so, when and what type? _____

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

_____ _____

Signature Date

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

What are your CURRENT symptoms?
PLEASE CIRCLE
0 means you have **NO SYMPTOMS** / **5** would be **MODERATE** / **10** would be **SEVERE**

P

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
Stress	0	1	2	3	4	5	6	7	8	9	10

TOP THREE CONCERNS

_____

_____

_____

E

Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10

T

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

T

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

(Males Only) Erectile Dysfunction 0 1 2 3 4 5 6 7 8 9 10

(Females Only) **First** day of last menstrual period _____

Please circle if you are experiencing any of the following symptoms:

Excessive hair loss Excessive fatigue Water retention/swelling in hands and/or feet Acne

_____

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 we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31st, 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 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 treatment 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 communication;
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. 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 202-747-5861

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____