



VIRTUAL HORMONE CLINIC

Dear Patient,

Congratulations! By reaching out for help to begin your journey to wellness, you have made one of the most important decisions in your life. My colleagues and I look forward to assisting you step-by-step as we work with you to restore your body to natural balance. You'll find everything you need to get started below. Once we receive your completed Registration Packet, we will call you to schedule your first phone consultation appointment at no charge to you. In subsequent consultations, we will develop an easy-to-follow treatment plan addressing your individual needs, By completing the forms, you will be one step closer to lasting relief from troublesome hormone-related symptoms.

Registration Packet includes:

- Patient Registration
- Health Questionnaire
- Consent for Hormone Supplementation Therapy
- Patient Release and Provider Privacy Notice

Send to:

Hormones in Balance/VW
Attn. HIB Scheduling
3156 State Street
Medford, OR 97504

Your Friend,
Nisha Jackson, PhD, MS, WHCNP, HHP
Founder/President
Ventana Wellness, PC
Rogue EMC, LLC
Body Analysis Clinic, Inc.
Hormone In Balance, PC

PATIENT REGISTRATION

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Home Phone: _____ Cell Phone: _____

Social Security #: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure (most recent): _____ Email Address: _____

Operations/ Hospitalizations (Include tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies and Adverse Medication Reactions (Please list drug and reaction)

Past Medical History: Have you had any of the following problems?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Acid reflux or hiatal hernia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraine | <input type="checkbox"/> Cholesterol Problem |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Environmental | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood clots or phlebitis | <input type="checkbox"/> Brain or nerve disease (stroke) | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other _____ | |

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

Please summarize your typical breakfast, lunch, dinner and snacks:

Please summarize your exercise regimen:

Are you taking birth control pills? Yes/No (Please circle) If you answer is yes please fill in the next line.

Brand _____ How long taking _____ When discontinued _____

Age Menstruation Began _____ Last Menstrual Period (Please put date of first day of last period) _____

Number of days of bleeding _____ Still Menstruating Yes/No (Please circle) Regular Yes/ No (Please Circle)

Number of Pregnancies _____ Number of live births _____

HEALTH QUESTIONNAIRE

	Absent	Mild	Moderate	Severe	Cyclic
Hot Flashes					
Night Sweats					
Vaginal Dryness					
Memory Loss					
Mental Fog					
Mood Swings					
Difficulty Sleeping/ Insomnia					
Anxiety					
Breast Tenderness					
Bloating					
Headaches					
Weight Gain					
Food Cravings					
Depression					
Low Libido					
Low Sex Sensation					
Irritability					
Fatigue					
Hair Loss					
Dry Skin/ Hair					
Acne/ Oily Skin					
Facial Hair					
Irregular Menses					

Medical Testing	Date	Normal	Abnormal
Complete Physical Exam		<input type="checkbox"/>	<input type="checkbox"/>
PAP Smear		<input type="checkbox"/>	<input type="checkbox"/>
Mammography		<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Ultrasound		<input type="checkbox"/>	<input type="checkbox"/>
Bone Density		<input type="checkbox"/>	<input type="checkbox"/>
General Blood Tests		<input type="checkbox"/>	<input type="checkbox"/>
Speicfic Hormone Test		<input type="checkbox"/>	<input type="checkbox"/>
Type of Hormone Test(s): _____			
Other:		<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>

Family History	Age	Alive (circle)	Medical Problems
Mother		Yes/No	_____
Father		Yes/No	_____
Sibling (Brother/ Sister)		Yes/ No	_____
Sibling (Brother/ Sister)		Yes/ No	_____
Sibling (Brother/ Sister)		Yes/No	_____
Other Relatives with Female health related problems:			
Relation:	Age:	Health Problem:	_____
Relation:	Age:	Health Problem:	_____

Patient Signature _____ Date: _____

Information and consent for Hormone Supplementation

Goals of Hormone Supplementation

- Alleviate symptoms associated with excess or deficiencies in hormone production
- Establish hormonal balance
- Provide protective benefits that were originally provided by the body's naturally occurring hormones

It is our intent to help you achieve the above goals through a process of measuring, supplementing, and monitoring your hormone levels. This requires an initial consultation and lab tests, followed by a visit to construct a plan of care. It may take up to 6 months or more of periodic office visits and lab work to fine tune your hormones.

It is our expectation that you receive yearly gynecological exams and regular breast monitoring for screening purposes while on hormone therapy. Gynecologic exams can be provided from a local designated medical provider. In addition to using the hormones as directed it is important that you make the recommended lifestyle adjustments to support the hormone use.

There are several options for hormone therapy.

- Compounded bio-identical hormones* – plant based estrogen and progesterone derived from wild yams and soy, and non-synthetic testosterone compounded at individualized doses into pills, creams, troches, or drops. This must be done at a compounding pharmacy. Insurance may or may not cover these products.
- Pharmaceutical bio-identical hormones – chemically based bio-identical estrogen and progesterone at fixed doses. Estrogen available in pills, patches and creams. Progesterone available in pills only.
- Traditional pharmaceutical hormones- chemically based or derived from equine estrogen. Not bio-identical estrogen, progesterone or testosterone. Available as pills.

*Bio-identical means having the same molecular structure as the human hormone.

Risks and Benefits

Benefits

- Reduction of hormonal symptoms
- Prevention of Osteoporosis
- Prevention of Colon Cancer
- Positive effect on cholesterol
- Possible protection against Alzheimer's disease
- Possible prevention of coronary heart disease.

Risks

- Possible increase in ischemic stroke. Conflicting data in large studies. In WHI study increase of 8 strokes per 10,000 women.
- Possible increase in breast cancer. In WHI study increase of 8 more cases of breast cancer per 10,000 women with estrogen and synthetic progesterone use. (We do not use synthetic progesterone in our patients). No increased risk with estrogen only use and no increase in mortality from breast cancer in this study.
- Increased risk of blood clots including venous thromboembolism and pulmonary embolism. Studies range from an increase of 3-18 more cases per 10,000 women. Transdermal dosing may decrease this risk.

Note: No large safety trials have been conducted using bio-identical estrogen and progesterone. The majority of large studies have used an oral dosage of synthetic estrogen and synthetic progesterone. It is unclear if the results of these studies can be applied to bio-identical hormones and transdermal regimens. Copies of studies on bio-identical hormones are available upon request.

Consent for Hormone Supplementation Therapy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the medical providers of Hormomes in Balance/VW. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me.

I understand that I will be in charge of administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

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 medical providers of Hormomes in Balance/VW any adverse reaction 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.

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 medical provider at Hormomes in Balance/VW is for hormone therapy only. I agree that I am and will be under the care of another health care provider for all other conditions.

I have been informed that insurance companies and Medicare will not pay for hormone supplementation therapy through this program. I therefore agree to pay for all services including laboratory and pharmacy charges if the insurance company does not pay for my services.

I have read and understand all of the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

I acknowledge that the cost of this program is \$100.00 per phone consultation. I am aware that the cost of my laboratory testing and my hormone prescriptions is a separate fee that I am responsible for paying directly to the laboratory or pharmacy. I agree to pay the full amount of the phone consultation prior to speaking with the practitioner. A phone representative will contact me at the time of my appointment and collect the \$100.00 by credit card before I am put through to the practitioner. I am responsible for filling out and returning all necessary registration and consent forms prior to being able to schedule my initial hormone phone consultation.

Patient Signature _____

Date _____

HIB / VW Signature _____

Date _____