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WrinkleFreeMD MED SPA & WELLNESS CLINIC

AUSTIN LOVE DOCTOR

New Patient Intake Form

Client Name: _____ DOB: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

Would you like to receive SMS appt reminders? ◉ Yes ○ No

Emergency Contact: _____

Phone: _____

Preferred Pharmacy: (Name and Address): _____

How did you hear about us?: _____

If referred by a current patient, please list their full name:

Medical History

Current Height: _____ Weight: _____ Age: _____

Please check all that apply:

- Bleeding Disorders
- Problems with scarring/Keloids
- Cancer (Specify): _____
- Diabetes: ◉ Type I ○ Type II
- Heart Disease
- High Cholesterol
- HIV/AIDS
- Hepatitis: ○ A ○ B ○ C
- Pacemaker/Defibrillator
- Polycystic Ovarian Syndrome
- Auto-Immune (Specify): _____
- Seizures
- Acne
- Cold Sores/Herpes
- Rosacea
- Precancerous Lesions
- Currently Pregnant or Nursing
- Accutane/Isotretinoin (when): _____
- Stress Urinary Incontinence
- Thyroid Disease
- Facial Surgeries
- Tattoos (areas): _____
- Other: _____
- Allergies: _____

Current medications (Including supplements and topical prescriptions):

Previous surgeries and dates:

Are you currently under the care of a physician for any medical conditions? ◯Yes ◯No
If yes, please explain:

Do you see a dermatologist regularly? ◯Yes ◯No
If yes, when was you last full skin exam?

Do you wear sunscreen daily? ◯Yes ◯No
If yes, what SPF?

Social History

Do you smoke? ◯Yes ◯No
If yes, how many cigarettes per day?
Do you drink alcohol? ◯Yes ◯No
If yes, how many drinks per week?
Do you use indoor tanning beds or self-tanner? ◯Yes ◯No
If yes, when was your last exposure?

Patient initials

Interests

Please check any of the following conditions that may be of interest to you:

- ☐ Aging skin
- ☐ Acne
- ☐ Wrinkles/fine lines
- ☐ Brown Spots/UV Damage
- ☐ Enlarged pores
- ☐ Rough texture
- ☐ Unwanted hair
- ☐ Redness/Rosacea
- ☐ Spider veins
- ☐ Sagging Skin/Laxity
- ☐ Unwanted fat
- ☐ Cellulite
- ☐ Scars
- ☐ Thinning hair
- ☐ Low libido
- ☐ Erectile dysfunction
- ☐ Vaginal dryness/laxity
- ☐ Pain with intercourse
- ☐ Brain Fog
- ☐ Melasma
- ☐ Stress Urinary Incontinence
- ☐ Joint/Muscle pain
- ☐ Irritability/Anxiety
- ☐ Fatigue/low energy
- ☐ Decreased sexual performance/satisfaction
- ☐ Other:_____

Please check any services you are interested in:

- ☐ Botox/Dysport
- ☐ Dermal Filler
- ☐ BBL
- ☐ Laser resurfacing
- ☐ Laser Hair Removal
- ☐ Acne Laser Therapy
- ☐ Skin Tightening
- ☐ Cool Sculpting
- ☐ HydraFacial MD
- ☐ Chemical Peels
- ☐ Microneedling
- ☐ Dermaplaning
- ☐ Vampire Facelift
- ☐ Bio-Identical Hormone Replacement
- ☐ Vaginal Laser Rejuvenation
- ☐ O-Shot
- ☐ P-Shot
- ☐ Gainswave
- ☐ Platelet-Rich Plasma
- ☐ Cellulite Reduction
- ☐ Hair Restoration
- ☐ PRP Joint Injections

If not listed above, what other procedures are you interested in?

_____

What cosmetic procedures have you had in the past: _____

Please list any at-home skincare products you are currently using:

_____

_____

_____

Terms

I understand that should I cancel or miss an appointment with less than a 24-hour notice, I will be subject to a missed appointment fee of $50.00. I understand that payment is due in full upon completion of any service. Certain services, such as laser treatments and CoolSculpting, require a non-refundable deposit to book.

I have received and read the Notice of Privacy Practices.
The information on this form is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Female Patient Questionnaire & History

Name: Today's Date:
(Last) (First) (Middle)

Date of Birth: Age: Weight: Occupation:

Home Address:

City: State: Zip:

Cell Phone: Home Phone:

E-Mail Address:

How did you hear about us? _____

In Case of Emergency Contact: Relationship:

Home Phone: Cell Phone: Work:

Primary Care Physician's Name: Phone:

Marital Status (check one): ◯ Married ◯ Divorced ◯ Widow ◯ Living with Partner ◯ Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment. If your spouse is your emergency contact, leave it blank.

Spouse's Name: Relationship:

Cell Phone: Work Phone: Home Phone:

Social:

- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I have completed my family.
- ☐ My sex has suffered.
- ☐ I haven't been able to have an orgasm.

Habits:

- ☐ I smoke cigarettes or cigars If yes, how many per day?
- ☐ I drink alcoholic beverages. If yes, how many per week?
- ☐ I drink more than 10 alcoholic beverages a week.
- ☐ I use caffeine. If yes, how much per day?

Medical History

Any known drug allergies:

Have you ever had any issues with anesthesia? ○ Yes ○ No
If yes, please explain:

Medications Currently Taking:

Current Hormone Replacement Therapy:

Past Hormone Replacement Therapy:

Nutritional/Vitamin Supplements:

Surgeries, list all and when:

Last menstrual period (estimate year if unknown):

Other Pertinent Information:

Preventative Medical Care:

- ☐ Medical/GYN exam in the last year
- ☐ Mammogram in the last 12 months
- ☐ Bone density in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy removal of ovaries

Birth Control Method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ Other:

Medical Illnesses:

- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ High blood pressure
- ☐ Heart bypass
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke and/or heart attack
- ☐ Blood clot and/or a pulmonary emboli
- ☐ Arrhythmia
- ☐ Any form of Hepatitis or HIV
- ☐ Lupus or other auto immune disease
- ☐ Fibromyalgia
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis) Diabetes
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Depression/anxiety
- ☐ Psychiatric disorder
- ☐ Cancer (type): Year:

BHRT Checklist for Women

Patients Name: **Date:**

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name:_____ Today's Date:_____

(Last) (First) (Middle)

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

☐ Abstinence ☐ Birth control pill ☐ Hysterectomy ☐ IUD ☐ Menopause ☐ Tubal ligation ☐ Vasectomy ☐ Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____ _____ _____

Print Name **Signature** **Today's Date**

INSURANCE DISCLAIMER

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to a Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Patients Full Name:

Signature: _____ Date:

Female Sexual Function Index (FSFI)

INSTRUCTIONS: These questions ask about your sexual feelings and responses **during the past 4 weeks**, Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential.

In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual sexual fantasy.

Sexual desire or **interest** is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

1) Over the past 4 weeks, how **often** did you feel sexual desire or interest?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never

2) Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

- ◯ 5 = Very high
- ◯ 4 = High
- ◯ 3 = Moderate
- ◯ 2 = Low
- ◯ 1 = Very low or none at all

3) Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

4) Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

5) Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

6) Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

7) Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

8) Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- ◯ 5 = Almost always or always
- ◯ 4 = Most times (more than half the time)
- ◯ 3 = Sometimes (about half the time)
- ◯ 2 = A few times (less than half the time)
- ◯ 1 = Almost never or never
- ◯ O = No sexual activity

9) Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never
- O = No sexual activity

10) Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

- 5 = Not difficult
- 4 = Slightly difficult
- 3 = Difficult
- 2 = Very difficult
- 1 = Extremely difficult or impossible
- O = No sexual activity

11) Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never
- O = No sexual activity

12) Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- 5 = Not difficult
- 4 = Slightly difficult
- 3 = Difficult
- 2 = Very difficult
- 1 = Extremely difficult or impossible
- O = No sexual activity

13) Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

14) Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied
- O = No sexual activity

15) Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- 5 = Very dissatisfied
- 4 = Moderately dissatisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately satisfied
- 1 = Very satisfied

16) Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

17) Over the past 4 weeks, how **often** did you experience discomfort or pain **during** vaginal penetration?

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never
- O = No sexual activity

18) Over the past 4 weeks, how did youexperience discomfort or pain **following** vaginal penetration?

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never
- O = No sexual activity

19) Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or painduring or following vaginal penetration?

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never
- O = No sexual activity

Submit Paperwork **Print Paperwork**

Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It **must** be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **3 days**, this includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

- Remember to get an appointment for your post-insertion blood work **6 weeks** after the insertion.
- Most women will need re-insertions of their pellets **3-4 months** after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

Additional Instructions:

_____

_____

_____

_____

_____

WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

•**FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

•**SWELLING OF THE HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

•**UTERINE SPOTTING/BLEEDING**: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

•**MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

•**FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

•**HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

•**HAIR GROWTH**: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.