ROCKY MOUNTAIN NATURAL MEDICINE

Dr. Jason Barker
Dr. Holly German
Dr. Sarah Kashdan
Dr. Danny Dowling

1030 Centre Ave - Suite B · Fort Collins, CO 80526
Phone: 970-237-1062 · www.fortcollins-naturalmedicine.com

Welcome!

Congratulations on your decision to get healthy, naturally!

Naturopathic Doctors are the nation's leading experts in preventive medicine and natural health care; you can feel confident you've made the right choice.

Please complete the attached intake forms that will help us to assess your current state of health. A full medical and symptom history is the start of this very individualized process.

Be certain to compile all forms and upload your pertinent recent labs ***at least 24 hours*** *prior to your appointment.*

We look forward to meeting with you, and helping to change your health for the better!

In Health,

Jason Barker, ND
Holly German, ND
Sarah Kashdan, ND LAc
Danny Dowling, ND

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CONFIDENTIAL INTAKE FORM

ROCKY MOUNTAIN NATURAL MEDICINE

Name: _____ **Date:** _____
(Please print clearly)

Address: _____

City: _____ **State:** _____ **Zip:** _____
_____

Email Address: _____
(We promise not to sell, trade or otherwise disclose your email to anyone. We use your email for scheduling and our newsletter that is full of great information and client-only specials).

Phone: _____ **Cell:** _____
(Please include area code)

I give Rocky Mountain Natural Medicine my permission:

To send text messages regarding my appointments **Yes** _____ **No** _____

To leave phone messages regarding my appointments. **Yes** _____ **No** _____

Birth date: _____

How did you hear about us?

_____

_____

If a friend referred you, is it okay for us to reach out to say "Thanks!" to them? Yes ___ No ___

Thank you and we look forward to helping you get healthier!

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DISCLOSURE STATEMENT AND INFORMED CONSENT
ROCKY MOUNTAIN NATURAL MEDICINE

This document is a binding agreement (the "Agreement") between ROCKY MOUNTAIN NATURAL MEDICINE Inc. ("We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows:

Consent for Treatment: You hereby consent to and authorize us to provide you with health care treatment that involves natural health and wellness. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk. You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the treatment after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment or procedure.

Services: Naturopathic Medicine is a branch of the healing arts distinct from other branches. Our services include the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, physical agents, and other therapies and modalities designed to support the body's natural healing processes. Our Naturopathic Doctors (ND) are registered under the Colorado Naturopathic Doctor Act. They are not Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Chiropractic (DC), or Doctors of Nursing (DNP) who are licensed under separate practice acts. As Naturopathic Doctors in Colorado, we do not prescribe, dispense, administer, or inject controlled substances (including general or spinal anesthetics) or practice medicine (including performing surgery, obstetrics, or administering ionizing radiation therapy). The only adjustments, manipulations, and mobilizations we perform are naturopathic manual therapies. We cannot recommend against a course of care recommended or prescribed by a licensed provider in another branch of the healing arts. Our office does not provide naturopathic treatment to children less than two years old. We recommend that our pediatric patients follow the CDC immunization schedule (copy attached) and have a relationship with a licensed pediatric health care provider.

Risks: I understand that no warranty or guarantee has been made to me as to the result of care. I realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment(s) planned for me. Naturopathic Medicine is generally considered safe but may involve some risks including, without limit: all of the risks disclosed with any preparations or medicines; allergic reaction; infection; pain or discomfort; weakness, fainting, or nausea; skin irritation, discoloration, or scarring; aggravation of symptoms; mood changes; and rarely, neurological injury and pneumothorax. Naturopathic Medicine may adversely interact with specific drugs and may be inappropriate during pregnancy.

Alternatives and Collaboration: Alternatives to Naturopathic Medicine include declining such care and consulting with others such as an MD, DO, DC, or DNP. Naturopathic Medicine is not a substitute for other types of health care and we encourage you to seek second opinions, have a relationship with an MD or DO, to communicate with all your providers about the care recommended in our office, and to authorize us to attempt to collaborate with your other providers. If applicable, please identify the provider with whom we should attempt to collaborate:
Provider: _____ Phone: _____

EMERGENCIES: If you are having a medical emergency, do not wait to seek care. Call 911.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Our fee schedule is attached. Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. You may terminate care at any time. No refunds are available for product purchases.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND! I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

Patient or Person with Authority to Consent: _____ **Date:** _____

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FINANCIAL POLICY
ROCKY MOUNTAIN NATURAL MEDICINE

Thank you for choosing Rocky Mountain Natural Medicine for your Naturopathic health care! We are committed to giving you the best care possible, and we want you to completely understand our financial policies. The following is a statement of our Financial Policy, which we need you to read and sign prior to any treatment.

- Payment is due at the time of service. Your financial responsibility to us is your cash fee. We accept cash, checks and major credit cards.
- We will collect and retain in a secure digital location your credit card for billing purposes upon scheduling.
- We reserve the right to charge your credit card on file for phone consultations and no show fees on the date of occurence.
- Your insurance plan will most likely not cover the services of our services. In the State of Colorado, Naturopathic health care is not yet covered by any insurance plans. However, you may submit your own claim to your insurance company; in rare events some portions of service may be reimbursable to you. Additionally, nutritional supplements prescribed may be eligible under your Health Savings Account. Ultimately it is your responsibility to understand what your insurance plan will and will not cover. We can help by providing you with the applicable codes to submit for reimbursement.
- Because our services are not covered by insurance, you are responsible for the complete charge. Payment is due upon the receipt from our office at time and date of visit.
- The following are some, but not all, of the costs of our services depending on complexity of the case:
  - New Patient: $325 / New Acupuncture patient: $175
  - Initial Follow Up: $175 / Acupuncture follow up: $85
  - Follow up visits: $150-$90, dependant on time/complexity

Laboratory services:

- We use a variety of testing methods to help with diagnosis. Some tests may be covered by insurance, and some are not. Your doctor will review them with you during your visit.
  For example:
  - Hormone profiles range from $185-$349
  - Food allergy tests range from $249-$350
  - Gastrointestinal tests range from $310-$418

I have read & understand RMNM's FINANCIAL POLICY AGREEMENT, and agree to be bound by its terms.

_____

Patient Signature (or Responsible Party if a minor) Date

_____

Printed Name

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT
ROCKY MOUNTAIN NATURAL MEDICINE

1030 Centre Ave, Suite B, Fort Collins, CO 80526
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This notice describes how your health information may be used and disclosed. Please review it carefully.

Your Rights

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request and we may say "no". If, however, you pay for a service or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: 1030 Centre Ave Suite B, Fort Collins, CO 80526, (970) 237-1062; or U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W. Washington, (971) C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

Your Choices

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT (CONT.)

We are also allowed or required to share your information in other ways, such as:

- Providing you with information related to your health
- Contacting you regarding appointments, treatment alternatives, or other health related services
- Incidental uses or disclosures (e.g. listing your name on a sign-in sheet etc.)
- Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence)
- Providing information to law enforcement or correctional facilities
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement
- Public health activities when requested by a public health authority or the FDA
- Responding to health oversight agencies
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process
- Research activities
- When necessary to avert a serious threat to health or safety
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities
- Providing information regarding your location, general condition or death to disaster relief agencies
- Providing information for workers' compensation claims
- Informing a family member, other relative, or close personal friend when:
- Information is relevant to the individual's involvement with your care
- To assist in your health care (pick-up prescriptions or documents, follow-up care instructions etc.)

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

Our Responsibilities

We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

Change to the Terms of this Notice

We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This notice is effective July 1, 2014. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Patient Acknowledgement

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

_____ _____
Signature of Patient/Legal Guardian *Date*

_____ _____
Print Patient Name (required) *Print Legal Guardian Name (if necessary)*

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

_____ _____
Signature of Practice Representative *Date*

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COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

Surprise Billing – Know Your Rights
Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?
If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:
Emergency Services: If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider: The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using which may be provided by any out-of-network providers. You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in OTHER situations, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed. If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745. Please contact your health insurance plan at the number on your health insurance ID card *or* the Colorado Division of Insurance with questions.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

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ACKNOWLEDGEMENT OF RECEIPT OF COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

This document is to be signed by the patient or a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, (print name)_____, hereby acknowledge that Rocky Mountain Natural Medicine has provided me with a copy of the Colorado Surprise/Balance Billing Disclosure.

My signature below indicates that I understand that Rocky Mountain Natural Medicine is an out-of-network facility which does not participate with any insurance providers. I further understand that all of the services I receive at Rocky Mountain Natural Medicine will be performed by out-of-network providers.

_____ _____
Signature Relationship to Patient (if signed by someone other than patient)

_____
Date

THIS SECTION IS TO BE COMPLETED BY ROCKY MOUNTAIN NATURAL MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Colorado Surprise/Balance Billing Disclosure from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgement

☐ Other (specify):_____

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CANCELLATION & MISSED APPOINTMENT POLICY

ROCKY MOUNTAIN NATURAL MEDICINE

At the time of booking your New Patient visit, we will contact you to secure your appointment with a $100 credit card deposit. Upon check out from your New Patient visit, we will apply the $100 to your visit fee.

New Patients:
We have a **48 hour cancellation policy for New Patient visits**. If you cancel under this time frame, we will retain your deposit and attempt to book you at another time.

*Please Note: Intake forms for New Patients need to be completed 24 hours **prior** to your visit. If not completed 24 hours before your appointment, it will be rescheduled.

Return Patients:
We require a 24 hour notice of cancellation. Same day cancellations will be billed at $75 for follow up visits to your credit card on file.

Thank you!

_____

Patient Signature (or Responsible Party if a minor) Date

_____

Printed Name

ROCKY MOUNTAIN NATURAL MEDICINE

HEALTH QUESTIONNAIRE

NAME:_____ **DATE:**_____

Present health issue(s): _____

_____

Do you have other health concerns? List in order of importance:

1) _____ 3) _____

2) _____ 4) _____

When did it/they begin? (date) _____

What percentage of the time does it bother you? (circle one) < 10% 25% 50% 75% 100%

What treatments (if any) have you received for your present health issue(s)?

_____

_____

Medications and prescriptions you are currently taking:	**Dosage**	**Reason for taking**	**How long?**

*Please bring all medications, prescription and over-the-counter, to your visit.

Supplements you are currently taking:	**Dosage**	**Reason for taking**	**How long?**

*Please bring all medications, prescription and over-the-counter, to your visit.

Hospitalizations, Major illnesses and/or trauma **Date**

_____

_____

Sleep (# of hours and quality): _____

Stress level (circle one): 1 Minimal 2 3 Somewhat minimal 4 5 Moderate 6 7 Somewhat extreme 8 9 Extreme

What life factors contribute to your stress levels?

_____

_____

Allergies: _____

Medications: _____

Food: _____

Environmental: _____

Please list the most common things you have for snacks and meals on an average day:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack/Dessert:

Do you have any food intolerances? Yes No
If yes, please list them_____
Are there any foods that you avoid eating? Yes No
If yes, please list them_____
What foods or drinks do you crave?_____
How much fluid do you drink daily?_____

Have you ever used alcohol? Yes No _____
If yes, how often do you currently drink? No longer drinking alcohol
Average 1-3 drinks per week Average 7-10 drinks per week
Average 4-6 drinks per week Average > 10 drinks per week____
Have you ever had a problem with alcohol? No _ Yes
If yes, please indicate time period (month/year): From _____ To _____

Have you ever used recreational drugs? No ___ Yes___

Have you ever used tobacco? No Yes **If yes, number of years _____ Amount per day_____ Year quit ____**
If yes, what type of nicotine have you used? Cigarettes Smokeless Patch/Gum Cigar Pipe
Are you exposed to second-hand smoke regularly? No ___ Yes __

Are you aware of any environmental toxins you've been exposed to such as:
Mold _____
Heavy metals _____
Pesticides _____
Other: _____

Have you ever had psychotherapy or counseling? No ___ Yes __
Currently? No _____ Yes **Previously?** No __ Yes **If previously:** From _____ To _____
What kind?_____
Comments:_____

Do you have a socially/emotionally supportive community? _____

Do you regularly experience joy in your life? _____

Hobbies and leisure activities:_____
_____

Do you exercise regularly? No _ Yes __
If so, how many times a week? _____

When you exercise, how long is each session? _____

What type of exercise is it? _____

What is your occupation: _____

FAMILY HISTORY: For each member of your family (except for spouse, family refers to blood or natural relatives), check the boxes for:

1. **Their present state of health**
2. **Any illnesses they have/had**

	Father	Mother	Siblings	Spouse	Child(ren)	Paternal Relatives	Maternal Relatives
Good Health							
Poor Health							
Deceased							
Age & Cause of Death. Please include accidents and suicides							
Alcoholism							
Allergies							
Asthma							
Alzheimer's or Dementia							
Autoimmune							
Blood Clotting Problems							
Diabetes							
Cancer or Tumor							
Cardiovascular							
High Blood Pressure							
Mental Health							
Arthritis							
Gastrointestinal							

Any other family history we should know about? No ___ Yes ___
If yes, please comment:

Medical History: for past medical conditions indicate year, for present conditions check appropriate box.

General Screening Exams	Month/Year
Last Dental Visit	
Last Eye Exam	
Mammogram	
Colonoscopy	
Last Physical Exam	

Head	PAST(year)	PRESENT
Allergies		
Dizziness		
Epilepsy/Seizures		
Fainting		
Headaches		
Migraines		
Sinus Problems		
Stroke		

Eyes, Ears, Nose, Throat	PAST (year)	PRESENT
Dark circles below eyes		
Distorted smell		
Distorted taste		
Dry eyes		
Ear fullness		
Ear pain		
Ear ringing/buzzing		
Eye pain		
Glaucoma		
Hearing problems		
Sore gums		
Sore throat		
Sore tongue		
Last Dental Exam?		
Swollen glands		
Vision problems		
Watery, itchy red eyes		
Yellowing eyes		

Heart	PAST (year)	PRESENT
Anemia		
Easy bleeding/bruising		
Heart attack		
Heart disease		
Heart murmur		
High blood pressure		
High cholesterol		
High triglycerides		
Varicose veins		

Urinary	PAST (year)	PRESENT
Bed wetting		
Hesitancy		
Infection		
Kidney disease		
Kidney stones		
Leaking/incontinence		
Pain/burning		
Urgency		
Yeast Infection		

General	PAST(year)	PRESENT
Alcoholism		
Cancer		
Cold intolerance		
Daytime sleepiness		
Diabetes		
Early waking		
Fatigue		
Fever		
Flushing		
Frequent illness		
Gout		
Heat intolerance		
Insomnia		
Mononucleosis		
Overweight		
Poor circulation		
Rheumatic fever		
Stroke		
Swollen ankles/feet		
Thyroid disease		
Weight gain		
Weight loss		

Musculoskeletal	PAST(year)	PRESENT
Arthritis		
Back pain		
Joint pain		
Muscle pain		
Back muscle spasm		
Calf cramps		
Chest tightness		
Foot cramps		
Joint redness		
Joint stiffness		
Muscle stiffness		
Muscle twitches		
Muscle weakness		
Tendonitis		

Medical History (continued): for past medical conditions indicate year, for present conditions check appropriate box.

Skin	**PAST** (year)	**PRESENT**
Acne		
Bumps on back of arms		
Cracked skin		
Cuticle problems		
Discoloration		
Dry skin		
Fingernail problems		
Hair changes		
Hair loss		
Hives		
Itching – where?		
Itchy feet		
Psoriasis		
Rashes		
Shingles		
Strong body odor		

Stomach/Digestive	**PAST** (year)	**PRESENT**
Bad taste in mouth		
Binge eating		
Black stools		
Bleeding gums		
Blood in stools		
Burning in throat		
Burping		
Canker sores		
Cold sores		
Difficulty swallowing		
Dry mouth		
Gas/bloating		
Gum disease		
Heartburn		
Hemorrhoids		
Hepatitis		
Hypoglycemia (low blood sugar)		
Indigestion		
Lip cracking		
Nausea/vomiting		
Rectal bleeding/fissures		
Stomach pain		
Ulcers		
Vomiting blood		

Digestive, Continued	✔
Frequency of BMs:	
1-3x daily	
3 or more daily	
4-5x week	
2-3x week	
1 or fewer per week	
Consistency	
Soft, well formed	
Often float	
Difficult to pass	
Diarrhea	
Constipation	
Thin, long, narrow	
Small, hard	
Loose but not watery	
Alternating hard & loose	
Color	
Medium brown consistently	
Very dark or black	
Greenish	
Visible blood	
Color varies often	
Yellow, pale, light brown	
Greasy, oily or shiny	

Respiratory	**PAST** (year)	**PRESENT**
Asthma		
Bad breath		
Bad odor in nose		
Bronchitis		
Cough		
Emphysema		
Hay fever		
Nasal stuffiness		
Pneumonia		
Post nasal drip		
Sinusitis		
Sleep apnea		
Sore throat		
Wheezing		

Medical History (continued): for past medical conditions indicate year, for present conditions check appropriate box.

Mental/Emotional/Nerves	PAST (year)	PRESENT
Anxiety		
Awaken rested		
Depression		
Difficulty concentrating		
Difficulty with balance		
Difficulty with judgment		
Difficulty with memory		
Difficulty with speech		
Difficulty with thinking		
Dizziness (spinning)		
Fainting		
Fear		
Fears/phobias		
Irritability		
Light headed		
Numbness		
Numbness/tingling		
Panic attacks		
Poor memory		
Sleeping difficulty		
Tremors		

Male Reproductive	PAST (year)	PRESENT
Enlarged breasts		
Genital pain		
Impotence		
Low sex drive		
Prostate enlargement		
Prostate infection		
Sexual Transmitted Infection		
Are you sexually active?		

Other	PAST (year)	PRESENT

Female Reproductive	PAST (year)	PRESENT
Age at menopause (if applicable)		
Age at onset of first period		
Birth control pills		
Bleeding after menopause		
Bleeding between periods		
Breast cysts		
Breast lumps		
Breast Implants		
Breast pain		
Breast tenderness		
Endometriosis		
Excessive bleeding		
Excessive pain with periods		
Fibroids		
Hormone replacement therapy		
Infertility		
Irregular periods		
IUD		
Last period (date)		
Low sex drive		
Number of miscarriages		
Number of pregnancies		
Ovarian cyst		
Painful intercourse		
PMS		
Polycystic ovarian syndrome		
Routine annual breast exam		
Routine mammogram		
Routine self breast exam		
Scanty periods		
Sexual Transmitted Infection		
Are you sexually active?		
Skipped periods		
Vaginal discharge		
Vaginal dryness		
Vaginal itching		