COLEMAN NATURAL HEALTH & WELLNESS, LLC
FEMALE QUESTIONNAIRE & CHECK LIST

NAME:____DOB:____________________________

HOW DID YOU HEAR ABOUT US: ____

HEIGHT:__________________WEIGHT:__________________RACE:___________________________

OF PREGNANCIES:_______# OF LIVE BIRTHS:______# OF MISCARRIAGES/ABORTIONS:______

CURRENT MEDICATIONS:____

CURRENT NON-PELLET ESTRADIOL DOSE & FORM:____

ALLERGIES:____

PREVIOUS ESTRADIOL DOSE (RETURNING PTS):____

HISTORY OF RENAL DISEASE:	YES	NO
ACTIVE LIVER DISEASE:	YES	NO
HYSTERECTOMY:	YES	NO
HISTORY OF CERVICAL CANCER:	YES	NO
HISTORY OF OVARIAN CANCER:	YES	NO
FIBROCYSTIC BREAST DISEASE:	YES	NO
HISTORY OF BREAST CANCER:	YES	NO
ACNE:	YES	NO
FACIAL HAIR:	YES	NO
HAIR LOSS:	YES	NO
HISTORY OF PCOS:	YES	NO
HISTORY OF HEAVY MENSES	YES	NO
HISTORY OF METABOLIC SYNDROME	YES	NO

PLEASE FORWARD THIS FORM ALONG WITH THE FOLLOWING INFORMATION PRIOR TO YOUR APPOINTMENT:

_____ BLOODWORK RESULTS (INC. HEMOGLOBIN A1C FOR DIABETIC PTS)

_____ MAMMOGRAM (MUST BE WITHIN THE LAST YEAR)

_____ MOST RECENT PAP SMEAR

_____ CURRENT PHYSICAL

_____ BONE DENSITY (IF YOU'RE AGE 40 OR OLDER)

COLEMAN NATURAL HEALTH & WELLNESS, LLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you that may be used and disclosed and how you can get access to this information. Please read it carefully.

Coleman Natural Health & Wellness, LLC is committed to high quality patient care. We are required by law to keep your health care information confidential. We are also required by law to provide you with this notice of our legal responsibilities. According to federal and state laws, we can use your private health information for the items listed below.

We may use and disclose personal and identifiable health information:

- **For Treatment: We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures.**
- **For Health Care Operations: We may use and disclose information about you for the general operation of our business. We may leave appointment information on an answering system or voice mail that is connected to any telephone number you may give us.**

Our staff members are trained to maintain your confidentiality during your visits to our practice: however, by federal and/or state laws, or other obligations, we may disclose your private information for certain reasons without your authorization. Some of those reasons may be: for public health risks, lawsuit proceedings, law enforcement requests, research, study purposes, outside business associate requests. You have the following rights regarding your personal health care information:

- **You have the right to ask for restrictions on the ways in which we use and disclose your medical information beyond those imposed by law. We will consider your request, but we are not required to accept it.**
- **You have the right to request that you receive communications containing your protected health information from us by alternative means. For example, you may ask that we only contact you at home or by mail.**
- **You have the right to inspect and copy any or all of your information, however your request may be required to be in writing, a fee may be charged and a minimum of 24 hours notice may be required. All requests are subject to verification.**
- **If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or correct the missing information. Under certain circumstances, we may deny your request.**
- **You have the right to file a complaint with us to correct the existing information below, or with the US Department of Health and Human Services.**
- **You have the right to provide us with an amendment to your authorization at any time, if you have authorized us usage of your heath information for reasons other than treatment, payment of health care operations.**

We will continue to evaluate our efforts to protect your personal information and make every effort to keep your personal information accurate and up to date. We will also use our professional judgment and our experience with common practice to make a reasonable decision for your best interest in allowing a person to pick up records. If we modify this notice we will provide you with advance notice of the changes and allow you the opportunity to opt out of such disclosure. I herby acknowledge receipt of the Notice of Privacy Practices given to me.

Printed Name: ____

Signed: ____

Date: ____

2 Pidgeon Hill Drive, Suite 490 ~ Sterling, VA 20165
Phone ~ 703-444-9949 Fax ~ 703-444-9950

COLEMAN NATURAL HEALTH & WELLNESS, LLC

PROGESTERONE

FREQUENTLY ASKED QUESTIONS

Who has to take progesterone?

Women who have a uterus and are on estrogen therapy.

Why do I need to take progesterone?

It stabilizes and protects the lining of your uterus. You must **never** stop taking the progesterone without discussing it with your doctor.

What if I don't take it consistently or not at all?

You will bleed. You will increase the chance of developing polyps or cancer in the uterine lining.

Why will I bleed?

Without progesterone, the lining starts to die, break down and sloughs off. The bleeding is a side effect of inadequate usage of progesterone.

What if I take it, but not as prescribed by my doctor?

You will most likely have some bleeding. You might experience light spotting to full blown bleeding. This can be very difficult to correct and may take months to straighten out.

What if I'm taking my progesterone correctly and I still bleed?

Continue taking it. The bleeding may indicate that the dose needs to be adjusted. Call the nurse or doctor for advice.

What if I am taking my progesterone for 10 - 12 days every month and I bleed after I'm done taking it?

This is normal. It's the reaction to the sudden lack of progesterone causing an artificial period.

What if I am taking my progesterone for 10 - 12 days every month and I DON'T bleed after I'm done taking it?

You will bleed if you need to (if the lining is thick enough). The important thing is taking the progesterone, not what happens when you stop.

What if my bleeding continues, even by adjusting the dose and taking my progesterone correctly?

You may need to have pelvic ultrasound to check the thickness of your uterine lining. You may also need an evaluation by your gynecologist.

What happens if I stop taking my progesterone and don't inform the doctor?

You are at risk of abnormal overgrowth of the lining, bleeding and the rare possibility of uterine cancer.

COLEMAN NATURAL HEALTH & WELLNESS, LLC

STATEMENT OF FINANCIAL RESPONSIBILITY

Initial Hormone Consult:

We will submit all initial consults to insurance for services rendered on your behalf. Any portion not covered by your insurance due to deductibles, co-payments or coinsurance are patient responsibility. Patients who do not have medical insurance will be expected to pay charges incurred on the date of service.

Insertion & Pellet Fees:

Most insurance companies are not covering Bio-Identical Hormone-Replacement Therapy at this time. Therefore patients are responsible for their balance at the time of service. Our office will provide a copy of the itemized bill at the end of the visit. Patients may submit this to their insurance for reimbursement if they choose to.

Insertion fee for initial visit:	$190.00
Insertion fee for follow up visits:	$80.00
Pellet fee for initial visit:	$55.00 each
Pellet fee for subsequent visits:	$50.00 each

Women typically receive 1-3 pellets
Men typically receive 7-10 pellets

These amounts can vary based on blood work results, medical history & consult with doctor

Payment Options:

Our offices accept Visa, MasterCard, and American Express. Our offices also accept personal checks or cash.
There will be a nonadjustable fee for all returned checks.

I have read the above statement and agree to its terms.

Print____

Signature____

Date____

COLEMAN NATURAL HEALTH & WELLNESS, LLC

Female Estradiol & Testosterone Hormone Acknowledgement Insertion Form

Although SottoPelle® Therapy Method has been approved for human use, there are few doctors who currently administer estradiol & testosterone pellets in the United States. I realize that this therapy is not FDA approved and is not the usual and customary means of hormone replacement. I have been told I am to have testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. I realize that testosterone can increase my energy, my libido, and increase my sense of well-being. I have also been told that I am to have estrogen inserted under my skin to also achieve a steady state of estrogen in my body. I realize that estrogen can eliminate my mood swings, anxiety and irritability.

I realize in the past, some athletes have abused testosterone. When they took huge quantities of synthetic testosterone, they may have incurred heart problems and elevated cholesterol. However, low-dose, non-oral, natural testosterone that is used in SottoPelle® Therapy Method has NOT been associated with these problems.

I understand there is a charge, depending on the number of pellets I am to receive. The precise amount is to be determined by Dr. Linda Coleman. As this procedure is often an expense not covered by insurance benefits, I understand payment is due in full at the time of service. If you wish to submit these costs to your insurance company on your own, we will be happy to assist you with the proper codes.

My signature certifies I have read the above and acknowledge that I have been encouraged to ask any questions regarding SottoPelle® Therapy Method. My questions have been answered to my satisfaction.

____ ______________________________

Patient Signature **Date**

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COLEMAN NATURAL HEALTH & WELLNESS

MEDICAL HISTORY

Name: ___________________________________ Date: ______________________
Address: ___________________________________ Age: ________ Sex: ________
Home Phone: _______________ Cell: _______________ Marital Status: __________
Emergency Contact / Phone: ____

ALLERGIES TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO

(If yes, please list medications and type of reaction)

____

____

MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBS, VITAMINS, ETC.)

Drug Name Dosage Drug Name Dosage

____
____
____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Please circle if you have had problems with or are presently complaining of any of the following):

• HIGH BLOOD PRESSURE	• CONSTIPATION	• ANXIETY
• DIABETES	• DIARRHEA	• DEPRESSION
• CANCER	• BLOOD IN STOOL	• ANEMIA
• HEART DISEASE	• ULCERS	• GOUT
• CHEST PAIN/TIGHTNESS	• CHANGE IN BOWEL HABITS	• NAUSEA
• SHORTNESS OF BREATH	• UNEXPLAINED WEIGHT GAIN	• VOMITING
• SWOLLEN ANKLES	• HEMORRHOIDS	• OTHER
• PALPITATIONS	• GALLBLADDER	•
• LIGHTHEADEDNESS	• COLITIS	•
• FREQUENT URINATION	• HEPATITIS/JAUNDICE	•
• RHEUMATIC FEVER	• THYROID DISEASE	•
• ASTHMA	• HEAD/NECK RADIATION	•
• BRONCHITIS	• HEADACHE	•
• PNEUMONIA	• KIDNEY DISEASE	•
• PERSISTENT COUGH	• KIDNEY STONES	•
• TUBERCULOSIS	• DIFFICULTY URINATING	•
• HAY FEVER	• ARTHRITIS	•
• ABDOMINAL DISCOMFORT	• LOW BACK PROBLEMS	•
• INDIGESTION	• SKIN DISEASE	•
• ALCOHOL ABUSE	• BLOOD DISORDERS	•
• DRUG ABUSE	• VENEREAL DISEASES	•

COLEMAN NATURAL HEALTH & WELLNESS

GYNECOLOCIGAL AND OBSTETRIC HISTORY

Women – Do you have or have you had:

Prolonged or abnormal bleeding: Yes No Describe: ___________________

Pelvic pain: Yes No Describe: ___________________

An abnormal pap smear: Yes No Describe: ___________________

An abnormal mammogram: Yes No Describe: ___________________

When was your last: Pap Smear: _______________ Mammogram: ________________

Number of pregnancies: __________Births: __________ Miscarriages: ____________

PLEASE LIST AND SUPPLY DATES FOR THE FOLLOWING

Operations: ____

____

Hospitalizations:

____

____

FAMILY HISTORY

Has any member of your family (including parents, grandparents, & siblings) ever had the following:

ILLNESS **WHICH FAMILY MEMBERS?** **AGE @ DIAGNOSIS**

Cancer (type) ____

Hypertension ____

Heart Disease ____

Diabetes ____

Stroke ____

Drug/Alcohol Abuse ____

Glaucoma ____

Bleeding Disease ____

Mental Illness ____

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