

Part 1 – Women's Medical History Intake Form

Congratulations on taking a positive step toward improving your health!
This online form contains the following:

- 1. Medical History Intake Form.
(Once completed, our Staff will then contact you to schedule an appointment. A credit card number will be required at the time of scheduling to reserve your appointment time.)
- 2. Information regarding Costs, Payment Policy, and Insurance information.
- 3. Client Provider Agreement

Please mail the following to the office prior to your scheduled appointment, if applicable:

- 1. Most recent Mammogram
- 2. Most recent Pap smear.
- 3. Most recent Bone Density Scan
- 4. All blood work completed within the last year
- 5. Any other information pertinent to your situation.

Thank you for your cooperation and I look forward to meeting with you soon.

Sincerely,
Lynn A. Chadd, MSN, ARNP, PS

Personal Information

Name *

First Last

Date of Birth *

 / / 

MM DD YYYY

Health Maintenance

Mammogram *

- N/A Normal Abnormal (please explain)

Date of last Mammogram

 / / 

MM DD YYYY

Pap smear *

- N/A Normal Abnormal (please explain)

Date of last Pap smear

 / / 

MM DD YYYY

Any history of abnormal PAP smears? *

No Yes (please explain)

Bone density *

N/A Normal Abnormal (please explain)

Date of last bone density test

/ / 
MM DD YYYY

Colon cancer screening type

Sigmoidoscopy Colonoscopy

Date of last colon cancer screening

/ / 
MM DD YYYY

If abnormal please explain

Diabetic blood screening *

N/A Normal Abnormal (please explain)


Date of last Diabetic blood screening

/ / 
MM DD YYYY

Cholesterol blood screening *

N/A Normal Abnormal (please explain)

Date of last Cholesterol blood screening

/ / 
MM DD YYYY

Lifestyle

Do you smoke? *

No Yes (how many per day?)

Please include previous smoking history. How much and for how long?

Do you drink alcohol? *

- No Yes (how much and how often?)

How many caffeinated beverages do you drink a day? *

- | | |
|-----------------------------------|-------------------------|
| <input type="radio"/> N/A | <input type="radio"/> 1 |
| <input type="radio"/> 2 | <input type="radio"/> 3 |
| <input type="radio"/> 4 | <input type="radio"/> 5 |
| <input type="radio"/> more than 5 | |

How many sodas do you drink per day? *

- | | |
|-----------------------------------|-------------------------|
| <input type="radio"/> N/A | <input type="radio"/> 1 |
| <input type="radio"/> 2 | <input type="radio"/> 3 |
| <input type="radio"/> 4 | <input type="radio"/> 5 |
| <input type="radio"/> more than 5 | |

Do you exercise regularly? *

- No Yes (what type and how often?)

Do you practice any stress management techniques? *

- No Yes (what and how often?)

What type of work do you do? *

Diet

Describe your typical daily food intake:

First Meal *

Second Meal *

Third Meal *

Snacks *

Medication Allergies

Any allergies to medications? *

No Yes

If yes, please list medications below

Medication #1

Type of Reaction (#1)

Medication #2

Type of Reaction (#2)

Medication #3

Type of Reaction (#3)

Please list current medications

Medication #1

Times per day (#1)

Medication #2

Times per day (#2)

Medication #3

Times per day (#3)

Medication #4

Times per day (#4)

Dose (#1)

Prescribed by (#1)

Dose (#2)

Prescribed by (#2)

Dose (#3)

Prescribed by (#3)

Dose (#4)

Prescribed by (#4)

Please list supplements

Supplement Name #1

Dosage (#1)

Times a day (#1)

Supplement Name #2

Dosage (#2)

Times a day (#2)

Supplement Name #3

Dosage (#3)

Times a day (#3)

Supplement Name #4

Dosage (#4)

Times a day (#4)

Past Medical History

Please check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Other Cancers |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Respiratory Conditions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Visual problems | <input type="checkbox"/> Osteoporosis or Osteopenia |

Other

Please List Surgeries:

Surgery #1

Surgery #2


Surgery #3

Surgery #4

Part 2 – Women's Form / Client Provider Agreement

Menstrual history

Date of last menstrual period *

/ / 
MM DD YYYY

Skip this section if no longer having periods

How often do you have periods?

On your heaviest days how often to you change your protection?

Average length (in days) of periods

Do you experience any pre-menstrual symptoms?

- No
 Yes (please describe)

Do you have any spotting in between your periods?

- No
 Yes (please describe)

Do you have painful periods?

- No
 Yes (what do you use for pain control, how often, and for how many days?)

Do you miss work due to the pain?

- No
 Yes
-

Obstetrical history

Number of pregnancies

Number of full term deliveries


Vaginal or c-sections deliveries

Current contraception *

- Tubal Ligation
- Third Choice
- Other contraception, please describe:
- Vasectomy
- Birth Control Pills

Menopause History

Last period *

/ / 
MM DD YYYY

Are you currently taking any hormone replacement therapy? *

- No
- Yes (please describe)

Have you had any problems with hormone replacement you have taken in the past? *

- No
- Yes (please describe)

Family History

Please choose the one that applies

Breast Cancer *

- N/A Maternal Paternal
 Maternal & Paternal

Other

Ovarian Cancer *

- N/A Maternal Paternal
 Maternal & Paternal

Uterine Cancer *

- N/A Maternal Paternal
 Maternal & Paternal

Colon Cancer *

- N/A Maternal Paternal
 Maternal & Paternal

Heart Disease *

- N/A Maternal Paternal
 Maternal & Paternal

Diabetes *

- N/A Maternal Paternal
 Maternal & Paternal

Osteoporosis *

- N/A Maternal Paternal
 Maternal & Paternal

Thyroid Disorders *

- N/A Maternal Paternal
 Maternal & Paternal

Please rate the severity of the current symptoms you are experiencing: *

| | None | Mild | Moderate | Severe |
|----------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Hot flashes | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Nights Sweats | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |

| | None | Mild | Moderate | Severe |
|-------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Vaginal Dryness | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Pain with intercourse | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Dry eyes | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Heavy periods | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Painful periods | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Uterine fibroids | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Endometriosis | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Water Retention | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Bloating | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Breast tenderness | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Depression | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Difficulty with memory | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Foggy thinking | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Mood swings | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Fatigue | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Sleep disturbance | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Anxiety | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Irritability | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Headaches | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Heart palpitations | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |

| | None | Mild | Moderate | Severe |
|----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Acne | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Hair loss | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Weight gain | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Decreased sexual desire | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Decreased sexual arousal | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Decreased sexual response | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Thinning skin | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Muscle Aches | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Joint Pain | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |

Other

Please circle if experiencing any of these symptoms

- | | |
|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleep apnea or stop breathing while sleeping |
| <input type="checkbox"/> Dozing while seated or inactive | <input type="checkbox"/> Nodding off while driving |

Please list any other concerns you would like to discuss during your appointment:

Maximum Allowed: 500 characters. *Currently Used: 0 characters.*

General Cost Information

- New Patient Consult appointment cost is \$250.00.

Your first follow-up appointment is included in this price.

Face-to-face appointments can be scheduled at the Peshastin, Washington office or at the Poulsbo Compounding Pharmacy.

Telephone appointments are also available for our distance patients; cost is the same as an in office appointment.

- Saliva Hormone Testing is \$175.00 --- Saliva Testing is required while being treated with bio-identical hormones. On average, saliva testing is completed when treatment is initiated, when prescriptions are adjusted and yearly when treatment has stabilized. Frequency of saliva testing will vary from person to person, depending on response to treatment.

Cost for New Patient Consultations and Saliva Hormone Tests are subject to change. Please confirm current fee schedule at time of scheduling appointment.

Payment Policy

- Payment is due at the Time of Service, as insurance billing services are not provided.

We accept Master Card, Visa, Checks, or Cash.

- Appointments will be reserved with a credit card or check. Please submit checks in advance of telephone appointments.

- For appointment cancellations, 48 hour notice is appreciated. Failing to show will result in a \$125.00 charge.

- Refunds for supplements and/or test kit purchases will be provided for up to 90 days after the purchase date. Restrictions may apply.

Insurance Information

- At the time that services are paid, an itemized statement will be provided. This will include all necessary insurance codes and information for self billing. Please consult with individual insurance plans for correct self billing instructions and appropriate forms. It is advised to make copies of all forms prior to submitting insurance claims.

- Please be informed that Lynn is an Out of Network Provider/Non-Preferred Provider and is not contracted with any insurance companies.

Medicare does not permit patients to self bill.

Client Provider Agreement

- I understand that Lynn Chadd, MSN, ARNP, PS does not accept insurance as payment and that I am responsible for payment at the time of service. I have read and agree with the cancellation policy.**

- I understand that if Medicare is my insurance—I cannot self bill Medicare for reimbursement as per Medicare's billing policy and that I am agreeing to pay "out of pocket" for all services—at the time of service.**


- I understand that the main focus of Lynn Chadd's practice is preventative healthcare, integrative care of chronic problems, and treating hormone imbalance in men and women. I understand that Lynn Chadd does not provide after hour, urgent, emergency or on call care. I have been advised to retain or maintain a Primary Care Provider for my other health care needs. I have been advised that in the event of an emergency I should dial 911 or go to my local emergency department.**

● I have provided accurate medical history information on the Medical History Intake Form.

● I understand that all of my records and information will be confidential according to “The Healthcare Privacy Act”.

Name: *

Birth Date *

| | | | | | |
|----------------------|---|----------------------|---|----------------------|---|
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |  |
| MM | | DD | | YYYY | |

Address *

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Please list any phone numbers where you would like to be contacted and/or messages left:

Home Phone

| | | | | |
|----------------------|---|----------------------|---|----------------------|
| <input type="text"/> | - | <input type="text"/> | - | <input type="text"/> |
| ### | | ### | | #### |

Work Phone

| | | | | |
|----------------------|---|----------------------|---|----------------------|
| <input type="text"/> | - | <input type="text"/> | - | <input type="text"/> |
| ### | | ### | | #### |

Cell Phone

| | | | | |
|----------------------|---|----------------------|---|----------------------|
| <input type="text"/> | - | <input type="text"/> | - | <input type="text"/> |
| ### | | ### | | #### |

Please include an E-mail Address for receiving messages, results and reminders:

Email

Please type in your name below to indicate you have read the above information.

Client Signature *

Date of Form *

| | | | | | |
|----------------------|---|----------------------|---|----------------------|---|
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |  |
| MM | | DD | | YYYY | |