# Robertson County Physical Medicine

2308D Memorial Blvd
Springfield, TN 37172
(615) 382-8144 Phone

## Personal Data

| | | |
|---|---|---|
| Name | Date | |
| Address | City State | Zip |
| Home phone | Work phone Cell phone | |
| Date of birth | Age | |
| Email | | |

## Primary Care Physician

| | | |
|---|---|---|
| Name | Phone | |
| Address | City State | Zip |

## Present Symptoms

Please briefly describe your symptoms.

What do you feel is the most important factor to your present symptoms?

## Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

| Date | Medical diagnosis, illness, accident |
|---|---|
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## Past Surgical History

| Date | Surgery |
|---|---|
| | |
| | |

**(615) 382-8145**

**Medications:** Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

| Name of Medication | Dosage | Dosing schedule |
|---|---|---|
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## Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC)

## Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

| Relationship | Age | Medical Problem(s)/ Cause of Death |
|---|---|---|
| Mother | | |
| Father | | |
| Brothers | | |
| | | |
| | | |
| Sisters | | |
| | | |
| | | |
| Children | | |
| Spouse | | |

## Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? _____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? _____

## Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

| | YES | NO |
|---|---|---|
| Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have _____ | | |
| Have you ever had elevated PSA? If yes, what was the abnormality and what follow up did you have _____ | | |
| Have you ever had a prostrate biopsy? | | |

Do you have a history of any of the following cancers:

☐ Lung ☐ Skin ☐ Other: _____
☐ Breast ☐ Lymphoma
☐ Colon ☐ Leukemia _____
☐ Prostate

## Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

| Hormone | Dose | Reason | Start Date | Stop Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Androgen Deficiency

Check which of these symptoms are troublesome and have persisted over time

☐ Low Libido
☐ Lack of Energy
☐ Decreased Strength/Energy
☐ Lost Height
☐ Decreased Enjoyment of Life
☐ Sad or Grumpy
☐ Problem with Memory/Concentration
☐ Decreased Erections
☐ Decreased Ability to Play Sports
☐ Fall Asleep After Dinner
☐ Sleep Disturbances
☐ Recent Deterioration of Work Performance
☐ Decreased Muscle Mass
☐ Hair Loss

## Adrenals

Check which of these symptoms are troublesome and have persisted over time

| Cortisol Excess | | Cortisol Deficiency |
|---|---|---|
| ☐ Sleep Disturbances | ☐ Heart Palpitations | ☐ Fatigue |
| ☐ Bone Loss | ☐ Headaches | ☐ Sugar Craving |
| ☐ Fatigue | ☐ Stress | ☐ Allergies |
| ☐ Weight Gain – Waist | ☐ Cold Body Temperature | ☐ Chemical Sensitivity |
| ☐ Loss of Muscle Mass | ☐ Sugar Cravings | ☐ Stress |
| ☐ Thinning Skin | ☐ Low Libido | ☐ Cold Body Temperature |
| ☐ Elevated Triglycerides | ☐ Hair Loss | ☐ Irritable |
| ☐ Breast Cancer | ☐ Increased Facial Hair | ☐ Arthritis |
| ☐ Irritable | ☐ Increased Body Hair | ☐ Heart Palpitations |
| ☐ Anxious | ☐ Acne | ☐ Aches/Pains |
| ☐ Memory Lapses | ☐ Nervous | |

## Thyroid

Check which of these symptoms are troublesome and have persisted over time

| Thyroid Excess | Thyroid Deficiency |
|---|---|
| ☐ Heat Intolerance | ☐ Cold Intolerance |
| ☐ Voice has become hoarse | ☐ Constipation |
| ☐ Heart Palpitations | ☐ Fatigued/Weakness |
| ☐ Weight Loss | ☐ Unexplained Weight Gain |
| ☐ Tremors/Shakiness | ☐ Inability to Lose Weight |
| ☐ Diarrhea | ☐ Stress |
| ☐ Nervousness/Anxious/Panic Attacks | ☐ Cold Body Temperature |
| ☐ Muscle Weakness | ☐ Irritable |
| ☐ Difficulty Conceiving/Infertility | ☐ Lack of Motivation |
| ☐ Coarse Dry Skin | ☐ Muscle Cramps |
| ☐ Insomnia | ☐ Aches/Pains |

## System Review – Check the appropriate box for each question.

| Constitutional / ID / Oncology | Yes | No | Not Sure |
|---|---|---|---|
| Have you had unexplained weight loss? | | | |
| Do you have fever and chills? | | | |
| Do you have night sweats? | | | |
| Do you notice swollen lymph nodes? | | | |
| Have you ever been diagnosed with cancer? | | | |
| Have you ever tested positive for HIV? | | | |
| Have you ever had a sexually transmitted disease? | | | |
| | | | |
| **Respiratory** | | | |
| Do you have a persistent cough? | | | |
| Do you frequently sneeze? | | | |
| Do you have excessive daytime sleepiness? | | | |
| Do you snore? | | | |

| | | | |
|---|---|---|---|
| Have you ever been diagnosed with asthma or emphysema or sleep apnea? | | | |

| **System Review** – Check the appropriate box for each question. | | | |
|---|---|---|---|
| **Cardiovascular** | **Yes** | **No** | **Not Sure** |
| Do you have chest pain? | | | |
| Do you have palpitations? | | | |
| Do you have shortness of breath? | | | |
| Do you have swelling in your legs? | | | |
| Do you have leg pain while walking? | | | |
| Have you been diagnosed with any heart condition?<br>Have you ever been diagnosed with a blood clot? | | | |
| | | | |
| **Gastrointestinal** | | | |
| Do you have problems swallowing food? | | | |
| Do you have nausea or vomiting? | | | |
| Do you have diarrhea? | | | |
| Do you have blood in your stool? | | | |
| Do you have abdominal pain or swelling? | | | |
| Have you ever been diagnosed with hepatitis or liver disease? | | | |
| | | | |
| **Endocrine** | | | |
| Do you urinate frequently or in larger amounts than usual? | | | |
| Do you have greater than normal urge to eat? | | | |
| Are you excessively thirsty? | | | |
| Do you have facial hair? | | | |
| Do you have acne? | | | |
| Have you ever been diagnosed with a thyroid problem? | | | |
| | | | |
| **Neurological** | | | |
| Do you have muscle weakness? | | | |
| Have you ever had a seizure? | | | |
| Have you ever fainted? | | | |
| Have you experienced double vision or blind spots? | | | |
| Have you ever been diagnosed with a stroke? | | | |
| | | | |
| **Urologic / Renal** | | | |
| Do you have burning when you urinate? | | | |
| Do you have urgency when you urinate? | | | |
| Do you urinate more frequently than others? | | | |
| Do you leak urine when laughing or coughing? | | | |
| Have you ever had any kidney problems? | | | |

Physician Notes:

# Patient SOAP Notes Form

| Patient Name | Date |
|---|---|
| | |
| **Reason for Visit** | **Type of Visit** ☐ Initial ☐ Follow-Up ☐ Final |
| | |

## Tests Ordered or Received

| | Ordered | Received |
|---|---|---|
| CBC | | |
| Skin Tests | | |
| | | |
| | | |
| | | |
| | | |
| PFT | | |
| Radiology | | |

Request Medical Records ☐ Yes

Review of Records:

## Subjective Data (Symptoms/Content)

## Objective Data (Observation/Labs)

| Assessment/Diagnosis or Impression | Code |
|---|---|
| | |
| | |
| | |

## Plan / Medications

Follow-Up Days ☐ Weeks ☐ Months ☐ PRN ☐

Signature

Time In AM ☐ PM ☐ Time Out AM ☐ PM ☐

Total Time:_____

# Disclosure / Liability Waiver
## Robertson County Physical Medicine
## Bio-Identical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Robertson County Physical Medicine. It's staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

## Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a prostate examination and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

Print Name Date