Byers Wellness Center-Female Patient Information

Welcome to Byers Wellness Center. We are excited to have you as one of our patients. In order for us to best serve you on your initial visit we ask that you complete this information and send it to us prior to your appointment time. You may fax this information to us at (770) 387-3425 or send via email to byerswellnesscenter@hotmail.com. If you have any questions, please don't hesitate to call us at (770) 387-3450.

General Patient Information

Patient's Name:		Date:
Address:		
City:	State:	Zip:
Date of Birth:	Social Security #:	
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Marital Status:		
Spouse's Name:		
Patient Employed By:		
Employer Address:		
How did you hear about us?		
In case of emergency, whom should we notify?		
Relationship to Patient?	Phone Number: ( )	

Menopause is a normal occurrence in a woman's life. During a woman's 40s, a gradual process leading to menopause begins. Women frequently experience symptoms for several years before menstruation ceases. The stage that comes before menopause is known as perimenopause. Sometimes symptoms are mild and barely noticeable – other times they can be extremely bothersome or distressing.

This questionnaire is intended to help you inform your doctor of any perimenopausal OR postmenopausal symptoms you may be experiencing. Together you can decide on a course of treatment—and begin discussing the things you need to know about your health during the menopause years.

PERSONAL HEALTH HISTORY/STATUS

Current Weight: _____ **Height: _____**

MENSTRUAL HISTORY

Last Menstrual Period ☐ Age at first menstrual period: ☐

Are/were your periods usually ☐ **Regular** ☐ **Irregular**

What was the first day of your last period? _____ How many days does your period last?_____

How many days does your period last? _____

How many days from the start of one period to the start of the next period? _____

Have your periods stopped? (Please check one) ☐ **Yes** ☐ **No**

If your period has stopped please explain:_____

Has there been changes in your flow?

☐ **Irregular bleeding** ☐ **Change in how often you have periods**

☐ **Changes in how many days you bleed** ☐ **Changes in flow**

Do you have bleeding between periods? ☐ **Yes** ☐ **No**

Do you have cramping with your periods? ☐ **Yes** ☐ **No**

If yes, please circle one: Mild Moderate Severe

Medicine taken for cramps? _____

Are you currently sexually active? ☐ **Yes** ☐ **No**

Method of Contraception: ☐ Sterilization ☐ Pills ☐ IUD ☐ Diaphragm ☐ Foam/gel ☐ Condoms

☐ Natural Family Planning/Rhythm ☐ Injectables ☐ Implant ☐ None ☐ Other

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Have you ever had any vaginal, cervical and/or tubal infection?

☐ **Yes**	Yeast	☐ **Yes**	Condyloma	☐ **Yes**	Herpes	☐ **Yes**	Gonorrhea
☐ **Yes**	Gardeneralla	☐ **Yes**	Bacterial Vaginitis	☐ **Yes**	Trichomonas	☐ **Yes**	Warts
☐ **Yes**	Syphillis	☐ **Yes**	PID	☐ **Yes**	Chlamydia	☐ **Yes**	Other

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Have you lost or gained weight recently? ☐ **Yes** ☐ **No** Usual weight range: _____

Do you have:

Night Sweats	☐ **Frequently**	☐ **Rarely**	☐ **No**
Hot flashes	☐ **Frequently**	☐ **Rarely**	☐ **No**
Pain w/Intercourse	☐ **Frequently**	☐ **Rarely**	☐ **No**
Vaginal Dryness	☐ **Frequently**	☐ **Rarely**	☐ **No**
Sleeping Problems	☐ **Frequently**	☐ **Rarely**	☐ **No**
Urine leaks when you cough or sneeze	☐ **Frequently**	☐ **Rarely**	☐ **No**
Difficulty concentrating/memory loss	☐ **Frequently**	☐ **Rarely**	☐ **No**
Mood Swings	☐ **Frequently**	☐ **Rarely**	☐ **No**
Migraines	☐ **Frequently**	☐ **Rarely**	☐ **No**
Depression	☐ **Frequently**	☐ **Rarely**	☐ **No**
Anxiety	☐ **Frequently**	☐ **Rarely**	☐ **No**
Decrease in sexual desire	☐ **Frequently**	☐ **Rarely**	☐ **No**
Decrease in energy level	☐ **Frequently**	☐ **Rarely**	☐ **No**

How have you dealt with these symptoms? (check all that apply)

Herbal medications/supplements	☐ **Yes**	☐ **No**	Specify:
Changed diet	☐ **Yes**	☐ **No**	Specify:
Layered clothing	☐ **Yes**	☐ **No**	Specify:
Increased exercise	☐ **Yes**	☐ **No**	Specify:

Do you consider your health to be: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Medical Illnesses:
Surgeries:
Allergies:

Bladder/Kidney Infections	☐ **Yes**	☐ **No**		
Fluid Retention	☐ **Yes**	☐ **No**		
Monthly Breast Exams	☐ **Yes**	☐ **No**		
Blood Clots in Legs	☐ **Yes**	☐ **No**	If yes when?	
Exercise	☐ **Yes**	☐ **No**	How often?	
Tobacco Use	☐ **Yes**	☐ **No**	Amount?	How Long?
Caffeine – containing beverages	☐ **Yes**	☐ **No**	How many cups per day?	
Street Drugs	☐ **Yes**	☐ **No**	Specify	
Other Medications	☐ **Yes**	☐ **No**	Specify	

OB/GYN HISTORY

How many times have you been pregnant?	
How many miscarriages have you had?	
How many abortions have you had?	
Have you had any Tubal/Ectopic pregnancies?	
How many vaginal deliveries have you had?	
How many Cesarean Sections have you had?	
Have you had any premature deliveries?	
Have you had any babies weighing less than 5lbs 8oz at birth?	
How many full term deliveries?	
Have you had any twin births?	
Did you have any complications with your pregnancies?	
If yes, list:	
What was the date of your last pap smear?	
Have you ever had an abnormal pap smear?	

If yes, how was it treated?

☐ Repeated Pap Smear	☐ Colposcopy	☐ Laser Surgery	☐ Cone Biopsy
☐ Cryosurgery (freezing)	☐ Hysterectomy	☐ Loop Excision	

Do you have any breast lumps, tenderness or discharge?	
Date of last mammogram?	
Was your last mammogram normal?	
Do you do self breast exams?	
Do you have a history of infertility?	

Do you have a history of DES exposure?	
Do you have any PMS symptoms?	
If yes, treatment?	

PAST MEDICAL AND FAMILY HISTORY

Do you have diabetes?	☐ Yes	☐ No
Do you have/had hypertension?	☐ Yes	☐ No
Do you have heart disease?	☐ Yes	☐ No
Do you have a heart murmur?	☐ Yes	☐ No
Do you have/had kidney disease?	☐ Yes	☐ No
Have you ever been treated for psychiatric problems?	☐ Yes	☐ No
Have you ever had rheumatic fever?	☐ Yes	☐ No
Do you have mitral valve prolapsed?	☐ Yes	☐ No
Have you ever had a urinary tract infection?	☐ Yes	☐ No
Have you ever had hepatitis/liver disease?	☐ Yes	☐ No
Have you ever had varicosities/phlebitis?	☐ Yes	☐ No
Do you have any thyroid problems?	☐ Yes	☐ No
Have you had any major accidents?	☐ Yes	☐ No
Have you ever had any blood transfusions?	☐ Yes	☐ No
Do you have asthma/lung disease?	☐ Yes	☐ No
Do you any drug allergies?	☐ Yes	☐ No
If yes, please list:		
Please list any GYN surgeries:		
Please list any other operations/hospitalizations (include year & reason):		
Please list any complications you have had from anesthesia?		
Please list any current medications you are on and the dosages:		
Have you had your cholesterol checked?	☐ Yes	☐ No
Date last checked? Was it normal:	☐ Yes	☐ No
Do you have arthritis? If yes, what type?	☐ Yes	☐ No
Do you have Lupus, Scleroderma or similar disease? If yes, please describe:	☐ Yes	☐ No

FAMILY HISTORY

Do you have a family history of breast cancer? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of colon cancer? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of ovarian cancer? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of osteoporosis? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of diabetes? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of hypertension? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of heart disease? If yes, whom?	☐ **Yes**	☐ **No**
Do you have a family history of kidney disease? If yes, whom?	☐ **Yes**	☐ **No**

Patient Signature: _____ Date: _____

FINANCIAL POLICY:

Byers Wellness Center does not file insurance for their patients. Payment for services must be made at time of service. We will be happy to provide you with a statement to file with your insurance company upon your request however we make no claim that our services will be reimbursed.

I understand that am responsible for my treatment at Byers Wellness Center and payment must be made at time of service.

Patient Signature: _____ Date: _____

PATIENT CONSENT TO LEAVE DETAILED MESSAGE INFORMATION

Dr. Byers requires our staff to obtain prior authorization to leave voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine/voice mail or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr. Byers and/or his staff to leave a message regarding treatment, test results or other necessary information.

1) On answering machine at home- Phone Number:_____
2) On voice mail at work- Phone Number: _____
3) On cell phone voice mail- Phone Number: _____

Patient's Signature: _____ Date: _____

I DO NOT consent to any messages being left on an answering machine other than caller's name and phone number.

Patient's Signature: _____ Date: _____

EMAIL AND TEXT MESSAGING REMINDERS:

Byers Wellness Center will send appointment reminders and other important communications at various times using your email and/or text messaging to your cell phone. Please provide us an email address and cell phone number you would like for us to use.

Email: _____ Cell Phone: _____

I authorize Byers Wellness Center to contact me via the above email address and cell phone number in regards to appointment information and other pertinent information regarding their services.

Patient Signature: _____ Date: _____

Disclaimer: We will never share your contact information with any other third party. Confidential patient information will never be sent through email or text messaging.

Byers Wellness Center – Sotto Pelle Treatment Pricing

FEMALE TREATMENT

Lab Work:

- Pre-Lab Work - All patients are required to have lab work completed prior to their first insertion. The fee for this lab work is $180.00
- Post-Lab Work – This test is generally taken 3 weeks after treatment until the baseline levels are set – then follow up labs are required once a year. The fee for this lab work is $170.00

COST OF TREATMENT:

The cost of the initial treatment includes your consultation with Dr. Byers and the fee for the insertion.

1st Treatment – Consultation ($259.00) + Insertion ($350.00) = $609.00

Follow Up Insertions: Typically follow up insertions are done every 3 to 4 months depending upon each patient. The cost for a follow up insertion is $350.00