protea
MEDICAL CENTER

Personal Data		
Name	Date	
Address	City State	Zip
Home Phone	Work Phone or Cell Phone	
Date of birth	Age	Blood Type
Current Height	Current Weight	Ideal Weight
Occupation		
Employer		
Marital Status		
Email		
How did you hear of us?		
Emergency Contact:	Name:	Phone Number:
Primary Care Physician		
Name	Phone	
Address	City State	Zip

As your cell phone and email are not considered "secure" communication devices:
Is it acceptable for us to contact you with medical information via e-mail? Yes / No
Is it acceptable for us to leave messages on a voice mail / answering machine for you? Yes / No

Patient Initials _____

Present Symptoms
Please briefly describe your present symptoms/concerns and treatments previously utilized.

Past Medical History	
Please list any medical problems or illnesses you have had or currently have. Include any hospitalizations and accidents with approximate dates. From high cholesterol to motorcycle accidents.	
Date	Medical diagnosis, illness, accident

Past Surgical History	
Date	Surgery

Allergies Please list all pharmaceutical allergies.

Medications: Please list ALL prescription medications.		
Prescription	Dosage	Dosing Schedule

Hormone Therapy History If you have ever been treated with any hormone replacement therapy please list hormones, doses and treatment durations:				
Hormone	**Dose**	**Reason**	**Start Date**	**Stop Date**

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		
Child		
Child		

Social History

Please remember that this information is strictly confidential.

Do you smoke cigarettes now or have you in the past?	YES	NO
If yes, how many packs are you currently smoking per day?		
How many total years did you smoke?		
Do you drink alcohol?	YES	NO
Have you used any illicit drugs within the last 24 hours	YES	NO
If yes, what illicit drug?		

Pulmonary Have you been experiencing any of the following?		
Shortness of breath with exertion?	YES	NO
Shortness of breath while lying down?	YES	NO
Shortness of breath while sitting?	YES	NO
Wheezing?	YES	NO

Urinary Please answer the following questions		
Have you been experiencing a frequent urge to urinate?	YES	NO
Have you ever had kidney stones?	YES	NO
Have you noticed blood in your urine?	YES	NO
Do you have frequent urinary tract injections?	YES	NO

Cardiovascular Have you been experiencing any of the following?		
High blood pressure	YES	NO
Low blood pressure	YES	NO
Arrhythmias	YES	NO
Edema or swelling of your legs	YES	NO
Palpitations	YES	NO
Have you ever been diagnosed with a heart murmur?	YES	NO

Gastrointestinal Have you been experiencing any of the following?		
Gas and/or bloating?	YES	NO
Acid reflux, heartburn or GERD?	YES	NO
Diarrhea or loose stools?	YES	NO
Blood in the stool?	YES	NO

Gynecological History

Please complete the following to the best of your knowledge

Date of last PAP smear? _____ Physician who performed? _____

Date of last mammogram? _____ Facility where performed: _____

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Are you using a birth control method? If yes, what kind?		
Are you still having menstrual periods? If yes, when was the first day of your last period? _____		

Please describe any problems you have with your periods: _____

_____

Periods are (were): ☐ regular ☐ irregular ☐ painful ☐ crampy ☐ heavy ☐ light ☐ other

Age periods began: _____ # days of bleeding _____ cycle length (days) _____

If you are no longer having periods, at what age did your periods stop? _____
If your periods stopped less than one year ago, how many months ago was your last period? _____

Did your periods stop because you had a hysterectomy? ☐ Yes ☐ No
If yes, what was the reason for the surgery? _____

Were the ovaries removed at the same time? ☐ Yes ☐ No ☐ Not Sure

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

☐ Vulva ☐ Ovary ☐ Other: _____
☐ Uterus ☐ Fallopian Tube
☐ Vagina ☐ Breast _____
☐ Cervix ☐ Colon

Estrogens

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

Estrogen Deficiency	Estrogen Excess / Progesterone Deficiency	
☐ Hot Flashes	☐ Mood Swings (PMS)	☐ Uterine Fibroids
☐ Night Sweats	☐ Cystic Ovaries	☐ Weight Gain – Hip Area
☐ Vaginal Dryness	☐ Tender Breasts	☐ Bleeding Changes
☐ Foggy Thinking	☐ Heavy Menses	☐ Elevated Triglycerides
☐ Memory Lapses	☐ Water Retention	☐ Breast Cancer
☐ Urinary Incontinence	☐ Sugar Craving	☐ Low Libido
☐ Tearful	☐ Nervousness	
☐ Depressed	☐ Irritable	
☐ Sleep Disturbances	☐ Anxious	
☐ Heart Palpitations/Arrhythmia	☐ Fibrocystic Breast	
☐ Bone Loss	☐ Headaches	
☐ Headaches	☐ Cold Body Temperature	

Androgens

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

Androgen Excess	Androgen Deficiency	
☐ Increased Facial Hair	☐ Low Libido	☐ Heart Palpitations/Arrhythmia
☐ Increased Body Hair	☐ Vaginal Dryness	☐ Headaches
☐ Acne	☐ Fatigue.	☐ Fibromyalgia
☐ Oily Skin	☐ Aches/Pains .	☐ Irritable
☐ Nervous	☐ Memory Lapses	☐ Thinning Skin
☐ Irritable	☐ Foggy Thinking	☐ Bone Loss
☐ Anxious	☐ Urinary Incontinence	
☐ Breast Cancer	☐ Depressed	
☐ Ovarian Cysts	☐ Anxious	
☐ Elevated Triglycerides	☐ Sleep Disturbances	
☐ Sleep Disturbances	☐ Apathy/Decreased Passion for Life	
☐ Prostrate Problems	☐ Decreased Muscle Mass	

Thyroid Check which of these symptoms are troublesome and have persisted over time		
Thyroid Excess	Thyroid Deficiency	
☐ Heat Intolerance ☐ Irritable ☐ Heart Palpitations/Arrhythmia ☐ Weight Loss ☐ Tremors/Shakiness ☐ Diarrhea ☐ Nervousness ☐ Anxious/Panic Attacks ☐ Insomnia ☐ Difficulty Conceiving/Infertility	☐ Cold Intolerance ☐ Constipation ☐ Fatigued/Weakness ☐ Unexplained Weight Gain ☐ Inability to Lose Weight ☐ Stress ☐ Cold Body Temperature ☐ Coarse Dry Skin ☐ Lack of Motivation ☐ Voice has become hoarse	☐ Aches/Pains ☐ Hair Loss ☐ Muscle Weakness ☐ Muscle Cramps

Is there anything else that you feel is important for us to know?

INFORMED CONSENT

I hereby permit Protea Medical Center and Dr. Brendan McCarthy, or his/her Associate Attending Physician of the same service, and assistants as may be selected and supervised by him/her to perform the following medical treatment, operation, or procedure (hereafter the "procedure"):

HCG Protocol
IV Therapy
IM Administration
Nutritional Consult
Botanical Medicine Formulation
Pharmaceutical based Medical Intervention
BHT Pellets
Acupuncture

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure.

If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment that is necessary.

_____

Signature of Patient **Date**

WITNESS:

I, _____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____

Signature of staff member **Date**

Cancellation Policy

We understand that unexpected circumstances may arise from time to time. For the consideration of the physician's time, as well as other patients waiting to be seen, a $25 cancellation charge will be applied to appointments cancelled less than 24 hours before the appointment time. For your convenience, we have an answering machine available for messages after hours and on weekends. Thank you for your cooperation.

I have read and understand the Cancellation Policy.

Signature of Patient Date

Doctor-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Muse be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the doctors including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the doctor and the doctor's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the doctor to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the doctor, any fee dispute, whether or not subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each part shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share or the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or the expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of Arizona law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Patient Initials_____

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Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Arizona statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the Arizona Code of Civil Procedure provisions relating to arbitrations shall govern the arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the doctor within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

→ _____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNIGN THIS CONTRACT YOU ARE AGREEING TO HAVE ANY MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ → By: _____
Doctor's or Duly Date Patient's Signature Date

_____ → _____
Print or stamp name of Doctor Patient's Printed Name

By: _____ By: _____
Signature of Translator (if applicable) Date Patient's Representative's Signature Date

_____ _____
Print Name of Translator Print Name and Relationship to Patient

Credit Card on File

Please fill in the following so we may simplify and expedite your checkout experience.

Information provided is safely stored and protected.

Credit Card Type: AMEX VISA MAST DISC

Card Number: _____

Expiration Date: _____

Security Code: _____

Name on card: _____

Patient Signature: _____