

# BUBOLO MEDICAL

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## Female Patient Questionnaire and History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ May we contact you via EMail? ( ) YES ( ) NO

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Address City State Zip

Who may we thank for referring you to our clinic? \_\_\_\_\_

I want to unlock exclusive offers by subscribing to the monthly newsletter

- Yes  
 No

I \_\_\_\_\_ grant my permission for the use of photographs, videos or case information for the following Bubolo Medical clinical purposes as indicated by my checked box below:

- Allow my picture to be used with identifying information  
 Only allow my pictures to be used without identifying who I am  
 I do not want any of my photos and or videos used

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## Social:

- ( ) I am sexually active.
- ( ) I want to be sexually active.
- ( ) I have completed my family.
- ( ) My sex has suffered.

## Habits:

- ( ) I smoke cigarettes or cigars \_\_\_\_\_ per day.
- ( ) I drink alcoholic beverages \_\_\_\_\_ per week.
- ( ) I use caffeine \_\_\_\_\_ a day.

## Nutritional Evaluation: Weight Loss

1. Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Desired Weight: \_\_\_\_\_
2. In what time frame would you like to be at your desired weight? \_\_\_\_\_
3. What is the main reason for your decision to lose weight? \_\_\_\_\_  
\_\_\_\_\_
4. When did you begin gaining excess weight?(Give reasons, if known) \_\_\_\_\_  
\_\_\_\_\_
5. What has been your maximum lifetime weight and when: \_\_\_\_\_  
\_\_\_\_\_
6. Previous Diets you have followed: \_\_\_\_\_  
\_\_\_\_\_
7. Give dates and results of previous weight loss attempts: \_\_\_\_\_  
\_\_\_\_\_
8. Is your spouse, fiancé or partner overweight? Yes No
9. Do you awaken hungry during the night? Yes No
10. How often do you eat out? \_\_\_\_\_
11. How often do you eat "fast food"? \_\_\_\_\_
12. Do you wake up in the morning hungry? \_\_\_\_\_
13. What time of the day are you most hungry? \_\_\_\_\_
14. What is your level of activity?
  - Inactive**- No regular physical activity with a sit down job
  - Light Activity**- No organized physical activity during leisure time
  - Moderate Activity**- Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling
  - Heavy Activity**- Consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
  - Vigorous Activity**- Participation in extensive physical exercise for at least 60 minutes per session 4 times per week
15. On an average how many hours of sleep do you get per night? \_\_\_\_\_

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## **Medical History**

Any known drug allergies: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_

Nutritional/Vitamins Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_

Current or History of STD's: \_\_\_\_\_

Are you actively trying to get pregnant or currently pregnant? \_\_\_\_\_

Are you currently Breastfeeding? \_\_\_\_\_

High blood pressure.

Breast cancer.

PCOS.

Fibromyalgia

Trouble passing urine or taking Flomax or Avodart.

Chronic liver disease (hepatitis, fatty liver, cirrhosis).

Diabetes.

Thyroid disease.

Arthritis.

Kidney Disease

High cholesterol.

Heart Disease.

Stroke and/or heart attack.

Blood clot and/or a pulmonary emboli.

Hemochromatosis.

Psychiatric Disorder.

Cancer (type): \_\_\_\_\_

Year: \_\_\_\_\_

## **Birth Control Method:**

Menopause  Birth Control pills

Hysterectomy  Copper/Metal IUD  Tubal Ligation

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**Symptom (Only check if it applies to you)**      **Never**      **Mild**      **Moderate**      **Severe**

<b>Mood Changes</b>				
<b>Memory Loss</b>				
<b>Mental Confusion</b>				
<b>Decreased Sex Drive/Libido</b>				
<b>Sleep Problems</b>				
<b>Difficult to Climax Sexually</b>				
<b>Painful Intercourse</b>				
<b>Breast Tenderness</b>				
<b>Loss of Vaginal Lubrication</b>				
<b>Vaginal/Bladder Leakage</b>				
<b>Loss of Vaginal Tightness</b>				
<b>Night Sweats/Hot Flashes</b>				
<b>Migraine/Severe Headaches</b>				
<b>Water Retention/Bloating</b>				
<b>Weight Gain</b>				
<b>Wrinkles</b>				
<b>Sagging Skin</b>				
<b>Loss of Hair</b>				
<b>Thinning Hair</b>				
<b>Fatigue</b>				

**Family History**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

1. Heart Disease
2. Diabetes
3. Osteoporosis
4. Thyroid Cancer
5. Prostate Cancer



**Weight Loss Program Consent Form**

I \_\_\_\_\_ authorize Bubolo Medical and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that there is no guarantee of results, much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

**I understand that I will not be entitled to a refund from Bubolo Medical for any reason, including poor outcomes. Prescription Drugs are NON REFUNDABLE PER FEDERAL LAW. ALL CHARGES ARE FINAL**

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concern the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parental consent for children (under 18 years of age)**

I, (print name of parent or legal guardian) \_\_\_\_\_ acknowledge that I have read and understood BUBOLO MEDICAL, LLC consent set forth above and acknowledge the risks associated with the weight loss program.

My son/daughter has also read and acknowledged the contraindications and waiver of risks. I give consent on behalf of my minor to voluntarily undergo the processes.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Signature: \_\_\_\_\_



**PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.**

1. I authorize Bubolo Medical to disclose my protected health information to:

- **Family member(s)**

Name	Phone Number

- **Non- Family Members**

Name	Phone Number

- **Myself Only**

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

- Test results, reports, and general health updates
- Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

<b>Email Address:</b>
<b>Phone Number:</b>

**Expiration or termination of authorization** – This authorization will remain in effect until terminated by the patient's personal representative, or another individual or legal entity authorized to do so by a court order or law.

**Right to revoke or terminate** – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Director.

**By signing below, I acknowledge that I have received, reviewed, understood, and will comply with the policies and procedures explained in the Bubolo Medical Office Policies and Procedures for Patients form.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Office Policies & Procedures For Our Patients

### OFFICE HOURS

Our office is available Monday - Thursday 9:00am - 6:00pm and Fridays 9:00am - 1:00pm. We close daily for lunch from 1:00pm - 3:00pm. We can be reached in Acworth at 770-975-1299 and in Sandy Springs at 404-255-6000.

### APPOINTMENTS & WALK - INS

Bubolo Medical is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates.

While we strive to schedule appointments appropriately, emergencies can and do occur in healthcare. We strive to give all of our patients the time they require. For this reason, we kindly request your patience and understanding should delay or rescheduling becomes necessary on your appointment date. We ask that you allow plenty of time to get to the office for your appointment. you may be asked to reschedule your appointment if you are more than 15 minutes late.

We will do our best to provide you with the same - day office visits and accept walk - ins for first available slots for visits. Please let our staff know if you have had any information changes since your last visit. You will be asked to fill out new registration forms annually so we may update your information.

### CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Bubolo Medical promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

### OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients.

- Closings will be displayed on our website [bubolomedical.com](http://bubolomedical.com) and on our Facebook page
- If you are scheduled for an appointment, you will receive a message by telephone.

### CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of \$0.75 per page. The law allows Medical Offices 30 days to complete requests for records.