ReVita' Life
239 Hurffville-Cross Keys Road
Suite 250
Sewell, NJ 08080

ReVita' Life
2301 Evesham Road
Suite 106
Voorhees, NJ 08043

Welcome and thank you for inquiring about Re-Vita-Life Bio-identical hormone replacement therapy. We have included a new patient information packet which we would appreciate you completing and returning prior to the time of your appointment. We thank you for filling out this paperwork as it is ultimately used to enhance the treatment best suited for your individual needs. Please also send along a copy of the front and back of your insurance card. Please tell us the date of your last GYN exam and provide a copy of your most recent pap smear. You will also be responsible for providing us with a recent mammogram report **prior** to your appointment, as well. Once you let us know what lab facility you are contracted with i.e. Quest or LabCorp, we will electronically send over a prescription for you to have your blood drawn. As a new patient to us your labs should be done 2 to 3 weeks prior to your consultation. There is no fasting required for this bloodwork.

We will accept your insurance (if we are in network with your plan) for services related to your consultation only. If you have a concern about the office visit or the labs being covered by your insurance, this will be the patient's responsibility to check with your specific plan. **See the following page for our list of labs that we may draw. You will be responsible for all co-pays, co-insurances and the full cost of the sub-dermal bio-identical pellets. We accept Visa, MasterCard, Diners Club and American Express.

Your initial consultation will include a thorough review of your medical history, quality of life analysis, laboratory results and treatment recommendations. This visit will take approximately one hour. Additionally, should hormone replacement pellet therapy be indicated as a treatment option desired by you following your consultation, you will be scheduled for your initial insertion within 1 -2 weeks. You will be charged based on the individualized dose of pellets you receive.

After your first insertion, you will be scheduled for a 6 week follow-up appointment. At that time, you will have a short consultation with your provider. That visit will be billed to your insurance carrier. Occasionally, patients may require a booster pellet(s) at this visit. If so, there is an additional fee per pellet inserted at the time of that insertion. Pending your own personal needs, responsive to therapy and laboratory evaluation, thereafter, pellet therapy is repeated every 3 –4 months. Your re-insertion consultation will be billed to your insurance carrier. You will be responsible for applicable co-pays and cost of the pellets received.

Please refrain from taking any baby aspirin/ Fish Oil or anticoagulants 5 days prior to pellet insertion.

*****Please note all correspondence and phone calls should be directed to our Sewell office*****

We look forward to caring for you.

Valerie
Phone: 856-262-4750
Fax: 856-262-1635

www.revitalifesouthjersey.com

Email: Revitalife@axiawh.com

The following is a list of labs that we will be drawing for the initial consultation:

- DHEA SULFATE
- FSH
- PROGESTERONE
- ESTRADIOL
- TRIIODOTHYRONINE,(T3) FREE SERUM
- TESTOSTERONE, FREE AND TOTAL
- THYROXINE (T4) FREE, DIRECT
- TSH
- VITAMIN D – 25 OH TOTAL

Re-Vita' – Life
Sub-dermal Bio-identical Hormones

Name (Last): _____ (First) _____ (Middle) _____

Date of Birth: _____ Email Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone#: _____ Alternate Phone #: _____

PLEASE SHARE WITH US THE REASON FOR YOUR VISIT TODAY (please include specific symptoms and how you are currently managing those symptoms):

_____
_____
_____
_____
_____
_____
_____
_____
_____

HOW DID YOU HEAR ABOUT RE-VITA'-LIFE?

_____

Name: _____ Date of Birth: _____

Please check the symptoms and their severity that brought you to seek our care:

SYMPTOM	**SEVERITY**			
	Never	**Mild**	**Moderate**	**Severe**
Depressed Mood				
Memory Loss/Forgetfulness				
Mental Confusion/Fog				
Mood Changes & Irritability				
Anxiety & Tension				
Migraines				
Decreased Libido/Sex Drive				
Difficulty to Climax Sexually				
Hypo sexual Responsive (taking long to climax)				
Sex is Painful				
Sex is Not Satisfying				
Sleep Issues (cannot fall or stay asleep)				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry Skin & Wrinkles				
Thinning of Hair				
Hair Falling Out				
Feeling Cold All the Time				
Joint Pain				
Osteoporosis				
Diabetes				
Cardiac Issue				

Name: _____ Date of Birth: _____

1. Any other symptoms or issues that are not listed but may be of concern to you?

   _____

   _____

   _____

   _____

2. What have you done to manage symptoms in the past?

   _____

   _____

   _____

   _____

3. Have you taken herbal medicine or supplements? YES/NO

   If yes, what have you taken and for how long?

   Did you get symptomatic relief?

4. How often do you have intercourse?

   Weekly?

   Monthly?

Name: _____ Date of Birth: _____

Medical History

GYN HISTORY

1. Are you still having periods? YES /NO

   If yes, what was the first day of your last period? _____

   Are your periods heavy? _____ Are your periods regular? _____

   How long do they last? _____

   If your periods are heavy and long, what was done by your gyn provider in the past for treatment of the abnormal bleeding:

◯ Ultrasound ◯ Endometrial Biopsy ◯ Endometrial Ablation

◯ D&C ◯ Hysterectomy ◯ Other

2. Are you currently using birth control, and if so, what method?

◯ Pills ◯ Diaphragm ◯ Depo ◯ Tubal ligation
◯ Withdrawal ◯ Vasectomy ◯ IUD ◯ Condoms

3. Are you menopausal? YES / NO
   If yes, how many year_____ Have you had a hysterectomy? YES / NO

4. Have you had any bleeding in menopause? YES / NO
   Please describe:
   _____
   _____
   _____

Name: _____ Date of Birth: _____

5. Have you had a pelvic ultrasound? YES / NO

   If yes, when? _____

   If yes, why was it done? _____

6. Have you ever had an endometrial biopsy? YES / NO

   If yes, when? _____

7. Date of last Pap smear? _____

   Have you ever had an abnormal pap test? YES / NO
   If yes, what was done? _____

◯ Repeat Pap smear ◯ Colposcopy ◯ Laser Surgery ◯ Cone biopsy

◯ Cryosurgery/freezing ◯ hysterectomy ◯ Loop excision/LEEP

8. Do you suffer from Breast Pain, Leaking or Discharge? YES / NO

9. If you are over 40, when was your last mammogram? _____

   Were the results normal? YES / NO

   If NO, what was recommended? _____

10. If you are over 50, what was the date of your last Bone Density Study/Dexascan?_____

    Were the results normal? YES / NO
    If NO, what was recommended? _____

11. Were you ever placed on estrogen replacement therapy? YES / NO

    If yes, what were you given and how long did you take it?

    _____
    _____

Name: _____ Date of Birth: _____

Medications

List any medications you are currently taking, including over-the-counter herbs & supplements:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any DRUG ALLERGIES? YES / NO

Do you smoke? YES / NO How long _____ Packs a day? _____

Do you use alcohol? YES / NO How much? _____

Do you use recreational drugs? YES / NO Please describe:

_____
_____

Name: _____ Date of Birth: _____

MEDICAL HISTORY

PAST MEDICAL HISTORY

◯ DIABETES
◯ HEART DISEASE
◯ HIGH BLOOD PRESSURE
◯ THYROID DISEASE
◯ STROKE
◯ LIVER DISEASE
◯ BLOOD CLOTS (IN EXTREMETIES OR LUNGS)
◯ ABNORMAL VAGINAL/UTERINE BLEEDING
◯ ENDOMETRIOSIS
◯ FIBROIDS/POLYPS
◯ ABNORMAL PAP
◯ ABNORMAL MAMMOGRAM
◯ PSYCHIATRIC DISORDER, if YES, please describe:

_____

ANY CANCER OF THE FOLLOWING ORGANS: (PLEASE CIRCLE ALL THAT APPLY)

UTEREUS OVARIAN BREAST COLON LUNG OTHER

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____

PAST SURGICAL HISTORY

List all GYN surgeries: _____

_____
_____
_____
_____

List all other surgeries:

_____
_____
_____
_____
_____

Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

◯ Breast Cancer Relative(s): _____

◯ Colon Cancer Relative(s): _____

◯ Diabetes Relative(s): _____

◯ Heart Disease Relative(s): _____

O OTHER CANCERS Relative(s): _____

Any other information you would like to share with us?

_____
_____
_____
_____
_____