Body By Barefoot Anti-Aging and Functional Medicine
10002 Shelbyville Road, Suite 110, Louisville, KY, 40223
Phone: 502-253-1838 Fax: 502-253-1841 Cell: 502-386-0655 drjbarefoot@aol.com

Last Name _____ First_____ MI___

Date of Birth _____ Social Security #_____

Address _____
City _____ State _____ Zip Code _____

Cell phone # _____

Email Address _____
Emergency Contact _____ Phone # _____
Primary Care Physician _____
Who referred you? _____

Health Insurance Portability and Accountability Act (HIPAA)
THESE QUESTIONS ARE BEING ASKED TO FULFILL OUR COMMITMENT TO PROTECT YOUR PRIVACY.

Is there anyone other than you that we can discuss your medical information?
☐ Yes ☐ No If yes, who? _____

May we contact you by cell phone or by email to confirm appointments, give test results, or billing information? ☐ Yes ☐ No

May we leave a message on your cell phone, or by email to confirm appointment, test results, or billing information? ☐ Yes ☐ No

May we give your social security number to a pharmacy for a controlled substance (i.e., testosterone)?
☐ Yes ☐ No

Upon request, may we fax or email you information concerning your health or billing information?
☐ Yes ☐ No

Preferred contact Cell [] Email []

_____ _____ _____
Signature of patient/guardian/parent/P.O.A Printed Name Date

I acknowledge the document titled: Notice of Privacy Practices

Signature _____ Printed Name _____ Date _____

REQUEST FOR ACCESS TO MEDICAL INFORMATION

_____ authorizes the release of his/her medical Information to ***Body by Barefoot***, 10002 Shelbyville Road, Suite 110, Louisville, KY, 40223.

The Practice Provides this form to comply with the Health Insurance Portability and accountability Act of 1996 (HIPPAA).

Patient Name: _____

Date of Birth: _____ SSN# _____

Please send:

_____ All Records _____X-rays _____ Other

_____ Labs _____ MRI report

_____ EKG _____ EMG/NCV

____ Fax to 502-253-1841

____ Fax to:

____ I will pick them up (call me when ready) Phone # _____

____ Mail them to _____

_____

____ Mail them to 10002 Shelbyville Rd, STE 110, Louisville, KY 40223

_____ _____

(Signature required) (Date)

Relationship to patient (if not patient): _____

Body By Barefoot Anti-Aging and Functional Medicine

CONSENT FOR HORMONE REPLACEMENT THERAPY

- I, _____, request from Jennifer Barefoot, MD, with *Body by Barefoot Anti-Aging and Functional Medicine* to prescribe for me Bioidentical Hormone Replacement Therapy (BHRT) if deemed necessary.

- I understand that BHRT is not specifically approved by the FDA for preventative medicine and my request for BHRT is off-label.

- I understand that the medical literature indicates that there may be health benefits to the use of BHRT and its long-term effects are undetermined.

- I understand that Jennifer Barefoot, MD, with *Body by Barefoot Anti-Aging and Functional Medicine* cannot guarantee any results or that there will be no harm. The potential health risks and benefits of using BHRT have been explained to me to my satisfaction.

- I understand that BHRT is purely elective and that it may not be deemed medically necessary by insurance companies.

- I certify that I have read the above consent and fully understand it. I believe that I have adequate knowledge upon which to base this BHRT informed consent.

- I fully understand what I am signing and herby request and consent to BHRT treatment.

_____ _____

Client Signature Date

_____

Jennifer Barefoot, MD

Female Medical History

Today's Date: _____

Name: _____ DOB: _____

Height: _____ Current Weight: _____ Goal Weight: _____

What is the purpose of your visit today (i.e., hormone replacement, weight loss, fatigue, etc.)? __
_____

Primary Care Provider: _____ Phone: _____
Pharmacy: _____ Phone: _____
Compounding Pharmacy: _____ Phone: _____

Medical Conditions (Please check all that apply):

- Heart Disease
- High Cholesterol/Lipids
- High Blood Pressure
- Cancer
- Thyroid Disease
- Hormone Related Issues
- Lung Condition
- Anxiety
- Blood Clotting Problems
- Diabetes
- Arthritis/Joint Problems
- Ulcers
- Headaches/Migraines
- Eye Disease
- Depression
- Other _____

Past Surgeries: _____

Have you had any of the following:

Bone Density _____	Date: _____	Results: _____
Mammogram _____	Date: _____	Results: _____
Pap Smear _____	Date: _____	Results: _____
Colonoscopy _____	Date: _____	Results: _____

Please list all medications you are currently taking:

_____

_____

_____

_____

Female Medical History

OB/GYN:

Number of Pregnancies _____ Number of Children _____

Any interrupted pregnancies? • Yes • No

Are you still having menstrual cycles? • Yes • No

When was your last period? _____ How many days did it last? _____

Are (or were) your cycles: • Regular • Irregular

Rate your menstrual flow: • Very Heavy • Heavy • Moderate • Light

Have you had a hysterectomy? • Yes • No Date if yes: _____

Have you had a tubal ligation? • Yes • No Date if yes: _____

What method of birth control are you using, if applicable? _____

Family History:

Colon Cancer • Family member: _____

Ovarian Cancer • Family member: _____

Breast Cancer • Family member: _____

Osteoporosis • Family member: _____

Diabetes • Family member: _____

Thyroid Disease • Family member: _____

Alzheimer's/Dementia • Family member: _____

Tobacco? • No • Yes How much/how often? _____

Alcohol? • No • Yes How much/how often? _____

Caffeine? • No • Yes How much/how often? _____

Illicit Drugs? • No • Yes How much/how often? _____

Have you ever been physically, emotionally, or sexually abused? _____

_____

What previous weight loss programs have you participated in? _____

_____

Please check any symptoms that apply to you, estimating their frequency/severity.

	Never / None	Rarely / Mild	Occasionally / Moderate	Frequently / Severe	Not Applicable
Hot Flashes					
Night Sweats					
Vaginal Dryness					
Foggy Thinking					
Memory Lapse					
Tearful					
Depressed					
Heart Palpitations					
Bone Loss					
Disturbed Sleep					
Headaches					
Aches and Pains					
Fibromyalgia					
Morning/Evening Fatigue					
Allergies					
Sensitivity to Chemicals					
Stress					
Cold Body Temperature					
Sugar Craving					
Elevated Triglycerides					
Weight Gain - Waist					
Decreased Sex Drive					
Loss of Scalp Hair					
Increase Body/Facial Hair					
Acne					
Mood Swings					
Tender Breasts					
Bleeding Changes					
Nervous					
Anxious					
Water Retention					
Fibrocystic Breasts					
Uterine Fibroids					
Weight Gain - Hips					
Decreased Stamina					
Decreased Muscle Size					
Rapid Aging					
High Cholesterol					
Swelling/Puffy Eyes/Face					
Slow Pulse Rate					

Decreased Sweating					
Brittle or Dry Hair					
Brittle or Dry Nails					
Thinning Skin					
Infertility Problems					
Constipation					
Diarrhea					
Bloating/Gas					
Rapid Heartbeat					
Hearing Loss					
Goiter					
Hoarseness					
Increased Urinary Urge					
Low Blood Sugar					
High Blood Pressure					
Low Blood Pressure					
Numbness – Feet or Hands					
Pain with Intercourse					
Lack of Motivation/Drive					

Any new symptoms that you wish to discuss today? _____