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

Male Medical History

Today's Date: _____

Name: _____ DOB: _____ Age: _____

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

Past Surgeries: _____

Have you had any of the following:

Bone Density _____	Date: _____	Results: _____
PSA Blood Test _____	Date: _____	Results: _____
Colonoscopy _____	Date: _____	Results: _____

Current Prescription Medications:

Medication Name	Dose	Frequency	Date Started

Over the Counter Medications (please list all products you use occasionally or regularly):

_____
_____
_____

Male Medical History

Nutritional/Natural Supplements (Please identify and list all products you are using):

_____

_____

_____

Allergies:

Medicine: _____

Food: _____

Environmental: _____

Other: _____

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: _____

Do you use:

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? _____

What previous weight loss programs have you participated in? _____

_____

Please check any symptoms that apply to you.

	Yes	No
Night Sweats		
Foggy Thinking		
Memory Lapse		
Tearful		
Depressed		
Heart Palpitations		
Irritability		
Disturbed Sleep		
Headaches		
Aches and Pains		
Morning/Evening Fatigue		
Allergies		
Stress		
Cold Body Temperature		
Sugar Craving		
Lack of Motivation/Drive		
Weight Gain - Waist		
Decreased Sex Drive		
Acne		
Mood Swings		
Nervous		
Anxious		
Water Retention		
Weight Gain – Hips, Chest		
Decreased Stamina		
Decreased Muscle Size		
Swelling/Puffy Eyes/Face		
Decreased Sweating		
Brittle or Dry Hair		
Brittle or Dry Nails		
Thinning Skin		
Constipation		
Diarrhea		
Bloating/Gas		
Rapid Heartbeat		

	Yes	No
Hearing Loss		
Goiter		
Hoarseness		
Erection or Potency Problems		
Loss of Morning Erection		
Dry Skin on Face or Hands		
Frequent Use of Alcohol – now or in the past		
Increased irritability, anger, bad temper		
Other:		

The age you are _____.

The age you feel _____.