

We can help you get started on hormone replacement therapy (HRT) and feel better through our Natural Balance Program. This program was developed to assist you in getting started on HRT. It empowers you through knowledge and education to approach and get the treatment you are looking for. Dr. Haendiges “Natural Balance Center” gets your life in balance and gets you the treatment you are looking for. “Natural Balance Center” is a full in-depth consultation with Dr. Haendiges whereby she will evaluate your symptoms, lab work of your hormones (if performed), and any other pertinent laboratory results. We then make an assessment and write a clinical consult note with a prescription for HRT that you take to your compounding pharmacist. We provide referrals for our current patients and for patients who participate in our “Natural Balance Center”.

STEP 1 – Consult with Dr. Haendiges

STEP 2 – Laboratory Assessment

I believe it is very important to utilize laboratory tests of hormone levels in our assessment of your hormonal status, and to incorporate this information into our recommendations. I encourage you to complete saliva testing as this is the least invasive and much more accurate means for testing.

If saliva testing is not an option you wish to pursue, we can also review blood tests if you have the appropriate tests available. We recommend the following labs when blood testing is done: estradiol, progesterone, testosterone (free and total), DHEAs, dihydrotestosterone. Also, you may consider requesting a TSH, free T3, total T3, free T4, and total T4.

STEP 3 – Collaborate with Dr. Haendiges

Once we have lab results, we can schedule our consultation with you. During this consultation, Dr. Haendiges will discuss risks and benefits of bioidentical hormone replacement therapy and discuss our recommendations for a customized regimen for you.

STEP 4 – Prescription Filled

Following our consultation with you, we then make an assessment and prepare a clinical consult note and we will work with your physician to make recommendations for HRT.

STEP 5 – Follow up in three months for possible Saliva testing

At any point, we will be available for phone or email consults.

I hereby release “Natural Balance Center” and all of its employees and contractors including physicians from any and all liability whatsoever associated or connected with “Natural Balance Center” consultation and/or use of hormone replacement. I hereby state that I am an adult and that I am aware there could be potential side effects associated with hormone replacement. I hereby agree to answer truthfully all of the medical questions on my questionnaire.

I understand that no doctor, nurse, pharmacy, or administrative personnel can guarantee that hormone replacement, even if prescribed, will provide the results I seek. Further, I understand that even if prescribed, I may suffer adverse effects from hormone replacement. I hereby release “Natural Balance Center” and all of its employees and contractors including physicians from any and all liability whatsoever associated with any adverse effects I may suffer from my use of hormone replacement.

I am participating in this program at my own choice, at my expense and my own liability and assume all responsibility for my use of hormone replacement. I fully understand that it is my responsibility to have an annual physical examination, including any suggested laboratory tests to ensure that I have no disease(s) which might make hormone replacement inappropriate for my condition.

Signed:_____ Date:_____

Women's Patient History Form – General Information

Date: _____

First Name: _____

Last Name: _____

Email Address: _____

Address: _____

City: _____

State, Zip: _____

Primary Phone (ex: 123-456-7890): _____

Secondary Phone: _____

Date of Birth (ex: MM/DD/YYYY): _____

Occupation: _____

Stress? Yes / No

Briefly explain: _____

What is your current living situation? Please check which is most appropriate:

Spouse Alone Significant Other Children Yes / No How many? _____

How did you hear about hormone replacement therapy?

What are your goals for hormone replacement therapy?

Current Physician(s): _____

Are any of your physicians open to prescribing HRT? Yes / No

If "Yes" please provide physician name: _____

Symptoms

Please identify your current symptoms and rate severity (mild, moderate, severe) and describe any special circumstances.

Symptoms	Yes	No	Severity (mild, moderate, severe)	Special Circumstances
Insomnia / difficulty sleeping				
Hot flashes				
Night sweats				
Cold intolerance (always cold when others are comfortable)				
Cold extremities				
Headache				
Loss of scalp hair				
Loss of pubic hair				
Dry coarse hair				
Dry skin				
Brittle nails				
Acne				
Poor skin elasticity				
Oily skin				
Wrinkles / lines on face				
Sun spots (face and/or hands)				
Puffiness of face and eyelids				
Blurred vision				
Thinning of skin				
Loss of bladder control				
Urinary Frequency / Urgency				
Constipation				
Frequent yeast infections				
Frequent urinary tract infections				
Vaginal Shrinking				
Vaginal Dryness				
Painful intercourse				
Diminished ability to reach orgasm				

Symptoms	Yes	No	Severity (mild, moderate, severe)	Special Circumstances
Low Libido				
Absent menses not related to menopause or hysterectomy				
Cramps				
Heavy or irregular menses				
Uterine fibroids				
Edema / water retention				
Bloating				
Fibrocystic breasts				
Swollen breasts				
Breast tenderness				
Lactation / mild production when not nursing				
Food cravings				
Fuzzy thinking				
Inability to concentrate				
Short term memory loss				
Depression				
Moodiness				
Irritability				
Emotional swings				
Anxiety				
Shortness of breath				
Heart palpitations				
Fatigue / lack of energy				

Symptoms	Yes	No	Severity (mild, moderate, severe)	Special Circumstances
Poor appetite				
Weight Gain				
Vocal hoarseness				

Objective Information

Please provide as much information as possible.

Height: _____

Weight: _____

What is your waist circumference at the navel? _____

Are you concerned with your current weight? Yes / No

Do you have weight management goals? Yes / No

If Yes, explain: _____

Blood Pressure: Last checked: _____ Reading: _____

Pulse: Last checked: _____ Rate: _____

Have you ever had a bone density scan? Yes / No

If Yes, Date: _____ Results: _____

Have you ever had your cholesterol checked? Yes / No

If Yes, Date: _____
 Results: Total _____ HDL _____ LDL _____ Triglycerides _____

Have you ever had your thyroid tested? Yes / No

If Yes, Date: _____
 Results: TSH _____ Total T4 _____ Free T4 _____ Total T3 _____ Free T3 _____

Do you have regular mammograms? Yes / No

If Yes, Date: _____ Results: _____

Have you ever had an abnormal mammogram? Yes / No

Have you ever had a breast biopsy? Yes / No

Have you had lab work of hormones? Yes / No

If Yes, was it within the last year? Yes / No

Age of first period: _____

Are you still menstruating? Yes / No

If Yes, date of last period? _____

Have you experienced a change in frequency or in intensity of your period? Yes / No

How many times have you been pregnant? _____

How many children have you delivered? _____

Your age at your first live birth: _____

Age of last live birth: _____

Age of last pregnancy: _____

Infertility: Yes / No

Your Current Medical Conditions

Disease State	Yes	No
Heart disease		
High blood pressure		
Stroke		
Varicose veins		
Clotting defects		
Diabetes		
Kidney disease		
Epilepsy		
Fractures		
Arthritis		
Colitis		
Gall bladder disease		
Asthma		
Chronic fatigue syndrome		
Fibromyalgia		
Cancer		
Fibroids		
Endometriosis		
Fibrocystic breast disease		
Abnormal vaginal bleeding		
Abnormal pap		
Hypothyroid		
Hyperthyroid		
Other: Please specify:		

Additional Information

Current Medications, hormone Therapy, Vitamins and/or Supplements: _____

Drug Allergies: _____

Please list any surgeries you have had including year (hysterectomy, oophrectomy/ovaries removed, tubal ligation, etc):

Is there any history of cancer in your family? (breast, ovarian, or endometrial) Yes / No
If Yes, what relationship and age of occurrence/diagnosis? _____

Is there any history of diabetes (type 2 / non-insulin dependent) in your family? Yes / No
If Yes, what relationship and age of occurrence/diagnosis? _____

Is there any history of hear attacks, coronary artery bypass, or stroked in your parent(s) or sibling(s)? Yes / No
If Yes, what relationship and age of occurrence/diagnosis? _____

Describe what you typically eat for the following.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Dessert: _____

Do you get regular exercise? Yes / No
If Yes, describe: _____
How many days per week: _____

Do you use tobacco products? Yes / No
If Yes, how many per day? _____ How long? _____

Do you use alcohol products? Yes / No
If Yes, how many drinks per day? _____ How long? _____

Do you use caffeine products? Yes / No
If Yes, How many drinks per day? _____ How long? _____

How did you learn about Dr. Haendiges' Natural Balance Center? Check the box that applies:

<input type="checkbox"/>	Friend
<input type="checkbox"/>	Patient of Dr. Haendiges
<input type="checkbox"/>	Pharmacist
<input type="checkbox"/>	Physician
<input type="checkbox"/>	Internet Search
<input type="checkbox"/>	Advertising
<input type="checkbox"/>	Newsletter

Saliva Hormone Testing

Saliva hormone testing enables you to measure your female or male hormone levels and compare them to the normal range for your age; this will help you and your healthcare provider in evaluating how hormone replacement therapy will or has influenced your hormone levels. We may also test your thyroid level if indicated.

It is highly recommended to get a saliva test, for a base line level to start with; repeating the test in 3 to 4 months. This way you will be able to evaluate if hormone replacement therapy has affected your levels. It is then recommended to repeat the test once a year thereafter. We suggest baseline testing for estradiol, progesterone, testosterone, cortisol and DHEA. Other tests such as melatonin, DHT and pyrilinks D (urine test) for bones may be suggested as appropriate.

This testing is cash payment just to cover our costs. We will give you a form to turn into your insurance company if your labs are done through our office with our diagnosis codes. Many insurance companies will pay and many will not. It is very individualized according to your benefits. In order to keep our prices as low as possible, we do not participate in billing for these labs. We will bill your office visit through the insurance company, but not your labs. This saves us a lot of time and cost and we are able to pass this onto you. These lab tests must be paid by cash or credit card only, no checks accepted. There will be a **20% Restocking Fee** for all returned, unused lab tests.

Driving Directions



Haendiges & Associates, PC
2030 W Boulevard
Kokomo, IN 46902

1. Head South on US 31
2. Take Downtown Exit for Kokomo
3. Continue on Washington St
4. Turn right at IN-22 (W Sycamore St)
5. Turn left at S Dixon Rd
6. Turn left at W Boulevard

1. Head East on IN St Rd 26
2. Turn left at 200 W
3. Turn right at W Boulevard

1. Head West on IN St Rd 22/US 35
2. Turn left at Park Rd
3. Turn right at W Defenbaugh St
4. Turn left at S Berkley Rd
5. Turn right at W Boulevard

1. Head North on US 31
2. Turn left at IN St Rd 26
3. Turn right at Park Rd
4. Turn left at W Boulevard

