AESTHETICS & PLASTIC SURGERY

# Hormone Replacement Therapy

## Getting Started:

1. Complete the New Patient Demographics
2. Email your forms to frontdesk@drkimplasticsurgery.com
3. You will be contacted within 24-48 hours to schedule your initial consultation.

Dr. Sugene Kim, M.D.
SGK Aesthetics & Plastic Surgery
10080 Research Forest Drive
The Woodlands, TX 77354
Phone: 281-363-4546 Fax: 281-882-8899
www.drkimplasticsurgery.com

# Patient Information Form

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ Email Address: _____

Employer: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Preferred Pharmacy: _____ Phone: _____

## Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

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

## How Did You Hear About Us?

| | |
|---|---|
| ☐ Stroll Magazine (Neighborhood?) | ☐ Gala (Which Non-Profit?) |
| ☐ Real Self | ☐ Woodlands Online |
| ☐ Social media (Which Platform?) | ☐ Billboard (Location?) |
| ☐ Doctor: | ☐ Friend or Relative? |
| ☐ Google, Bing, etc: | ☐ Other: |

**Failure to call and cancel your appointment 24 hours in advance or arrive for your scheduled appointment will be subject to a $100 cancellation fee. When a procedure is scheduled a $1,000.00 deposit is required. Full payment is required at the time of the pre-op appointment. Deposits for non-surgical procedures are non-refundable. We are unable to accept personal checks. It is the patients' responsibility to provide a translator.**

**Signature:** _____ **Date:** _____

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## Areas of Interest (mark all that apply):

| Facial Procedures | Breast Procedures | Body Procedures | Other Services/Non-Surgical |
|---|---|---|---|
| ☐ Brow Lift | ☐ Breast Augmentation | ☐ Abdominoplasty (Tummy Tuck) | ☐ Botox and/or Dermal Fillers |
| ☐ Eyelid Surgery | ☐ Breast Implant Exchange | ☐ Thigh Lift | ☐ Laser Treatments |
| ☐ Face or Neck Lift | ☐ Breast Implant Removal | ☐ Arm Lift | ☐ Chemical Peels |
| ☐ Rhinoplasty (Nose Job) | ☐ Breast Lift | ☐ Body Tite | ☐ Microneedling |
| ☐ Ear Surgery | ☐ Breast Reduction | ☐ Liposuction (area): | ☐ Vaginal Rejuvenation |
| ☐ Double Chin Treatment | ☐ Breast Reconstruction | ☐ Labiaplasty | ☐ Hormone Replacement Therapy |
| ☐ Chin Augmentation | ☐ Gynecomastia (Men) | ☐ Mons Lift (Pubic Area) | ☐ Weight loss Semaglutide/Tirzepatide |

How long have you considered this procedure? Month(s) Year(s)

When are your plans for surgery?

What are your concerns regarding the procedure?

What is your price range? Are you interested in financing options? ☐ Yes ☐ No

Current Bra Size: Desired Bra Size:

Current Implant Type (if you have implants): Saline Silicone Desired Implant Type: Saline Silicone

Date of Last Mammogram: Results: ☐ Normal ☐ Abnormal

Explanation of Results:

## Specific Medical History

**Height:** **Weight:** **Is this your goal weight?** ☐ **Yes** ☐ **No** **What is your goal weight?**

| Have you or do you still have: | Yes | No | Description |
|---|---|---|---|
| ADHD | ☐ | ☐ | |
| Anemia | ☐ | ☐ | |
| Anxiety | ☐ | ☐ | |
| Arthritis or Gout | ☐ | ☐ | |
| Autoimmune Disease | ☐ | ☐ | |
| Bleeding Disorder | ☐ | ☐ | |
| Breathing Disorder | ☐ | ☐ | |
| Cancer | ☐ | ☐ | |
| Depression | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Epilepsy or Seizures | ☐ | ☐ | |
| Fatigue | ☐ | ☐ | |
| Heart Trouble | ☐ | ☐ | |
| Hepatitis | ☐ | ☐ | |

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| | | | |
|---|---|---|---|
| Herpes or Cold Sores | ☐ | ☐ | |
| High or Low Blood Pressure | ☐ | ☐ | |
| HIV or AIDS | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | |
| Liver Trouble | ☐ | ☐ | |
| Lung Disease | ☐ | ☐ | |
| Migraines | ☐ | ☐ | |
| Obesity | ☐ | ☐ | |
| Problem Scarring | ☐ | ☐ | |
| Psychiatric Care | ☐ | ☐ | |
| Reaction to Anesthesia | ☐ | ☐ | |
| Reflux or GERD | ☐ | ☐ | |
| Repeated Infections | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Thyroid Trouble | ☐ | ☐ | |
| Urinary Incontinence | ☐ | ☐ | |
| Others Not Listed: | | | |

***If diagnosed with breast cancer, please fill out the following:***

Type of Cancer? _____ When was your diagnosis? _____
BRCA Positive? ☐ Yes ☐ No Which breast was affected? ☐ Left ☐ Right
Radiation Treatment? ☐ Yes ☐ No Chemotherapy? ☐ Yes ☐ No

**Medications**

Are you taking any medications, vitamins or herbal or dietary supplements? ☐ No

☐ Yes, please list:

**Allergies and Sensitivities**

Are you allergic to medications, foods, seasonal/environmental elements or anesthesia? ☐ No

☐ Yes, please list:

**Surgery History**

Have you ever had surgery? ☐ No

☐ Yes, please list:

**Social History**

Are you pregnant? ☐ Yes ☐ No Do you plan on having future pregnancies? ☐ Yes ☐ No

| Do you… | Yes | No | Description |
|---|---|---|---|
| Smoke | ☐ | ☐ | How Much: |
| Drink | ☐ | ☐ | How Often: |
| Use illegal drugs | ☐ | ☐ | Explain: |

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Exercise ☐ ☐ How Often: _____

Eat a special diet ☐ ☐ What Type: _____

Have children ☐ ☐ How Many: _____

**Family History**

| Have any blood relatives had any of the following? | Yes | No | Description/Relative Relationship |
|---|---|---|---|
| Arthritis/Gout | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Autoimmune Disease | ☐ | ☐ | |
| Bleeding Disorder | ☐ | ☐ | |
| Breast Cancer | ☐ | ☐ | |
| Cancer | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Epilepsy/Seizures | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | |
| Lung Disease | ☐ | ☐ | |
| Mental Illness | ☐ | ☐ | |
| Migraine Headache | ☐ | ☐ | |
| Obesity | ☐ | ☐ | |
| Reaction to Anesthesia | ☐ | ☐ | |
| Repeated Infections | ☐ | ☐ | |
| Severe Allergies | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Thyroid | ☐ | ☐ | |

Others Not Listed: _____

**I have read this questionnaire and disclosed my medical history to the best of my knowledge.**

**Patient Signature:** _____ **Date:** _____

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# AMS Checklist – BEFORE HRT

## Male ONLY Questionnaire

| Place and "X" for EACH symptom you are currently experiencing. Please mark only ONE box. For symptoms that do not apply, please mark NONE. | None 1 | Mild 2 | Moderate 3 | Severe 4 | Extremely Severe 5 |
|---|---|---|---|---|---|
| 1.) **Decline in your feeling of general well-being.** (general state of health, subjective feeling) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2.) **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3.) **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.) **Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.) **Increased need for sleep, often feeling tired** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6.) **Irritability** (feeling aggressive, easily upset about little things, moody) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7.) **Nervousness** (inner tension, restlessness, feeling fidgety) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8.) **Anxiety** (feeling panicky) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9.) **Physical exhaustion/ lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, achieving less, of having to force oneself to undertake activities.) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10.) **Decrease in muscular strength** (feeling of weakness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11.) **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12.) **Feeling that you have passed your peak** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13.) **Feeling burnt out, having hit rock-bottom** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14.) **Decrease in beard growth** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15.) **Decrease in ability/frequency to perform sexually** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16.) **Decrease in the number of morning erections** | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17.) **Decrease in sexual desire/ libido** (lacking pleasure in sex, lacking desire for sexual intercourse) | ☐ | ☐ | ☐ | ☐ | ☐ |

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**Do you have cold hands and feet?** ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

**Do you have gas, bloating or abdominal pain after eating?** ☐ Yes ☐ No

**Please select your WEEKLY Activity Level based on this criteria ➔** *Physical activity that accelerates heart rate / Breathlessness*

☐0-1 day per week (Low) ☐2-3 days per week (Average) ☐More than 3 days per week (High)

**Please list any prior hormone therapy?**_____

_____**Recent PSA:**_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

**History of Prostate problems or Biopsy. If so, please provide details.**_____

## MRS Checklist – BEFORE HRT

### Female ONLY Questionnaire

| **Place and "X" for EACH symptom you are currently experiencing. Please mark only ONE box. For symptoms that do not apply, please mark NONE.** | **None 1** | **Mild 2** | **Moderate 3** | **Severe 4** | **Extremely Severe 5** |
|---|---|---|---|---|---|
| **1.) Hot flashes, sweating** (episodes of sweating) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **2.) Heart discomfort** (unusual awareness of heartbeat, heart skipping, heart racing, tightness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **3.) Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **4.) Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **5.) Irritability** (feeling nervous, inner tension, feeling aggressive) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **6.) Anxiety** (inner restlessness, feeling panicky) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **7.) Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **8.) Sexual problems** (change in sexual desire, in sexual activity and satisfaction) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **9.) Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **10.) Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse) | ☐ | ☐ | ☐ | ☐ | ☐ |
| **11.) Joint and muscular discomfort** (pain in the joints, rheumatoid complaints) | ☐ | ☐ | ☐ | ☐ | ☐ |

**Do you have cold hands and feet?** ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

**Do you have gas, bloating or abdominal pain after eating?** ☐ Yes ☐ No

**Please select your WEEKLY Activity Level based on this criteria ➔** *Physical activity that accelerates heart rate / Breathlessness*

☐0-1 day per week (Low) ☐2-3 days per week (Average) ☐More than 3 days per week (High)

**Please list any prior hormone therapy.**_____

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**Please select ALL areas you are interested in treatment recommendations**

**Upper Face**
- ☐ Sunken temples
- ☐ Low sitting eyebrows
- ☐ Forehead lines
- ☐ Frown lines between eyebrows

**Eyes**
- ☐ Crow's feet and wrinkles
- ☐ Excess upper eyelid skin
- ☐ Dark circles
- ☐ Bags under eyes
- ☐ Hollowness under eyes
- ☐ Crepey skin around eyes

**Middle Face**
- ☐ Loss of volume in cheeks
- ☐ Lack of cheek bones
- ☐ Bunny lines on nose

**Lower Face**
- ☐ Nasolabial folds/ smile lines
- ☐ Thin lips
- ☐ Wrinkly lips
- ☐ Gummy smile
- ☐ Lines around lips
- ☐ Marionette lines/mouth corners
- ☐ Jowls
- ☐ Sagging skin on lower face
- ☐ Poorly defined jaw line
- ☐ Small/recessed chin
- ☐ Chin dimpling
- ☐ Double chin
- ☐ Wide jaw/face slimming
- ☐ Clenching/grinding

**Skin (Face)**
- ☐ Brown Spots
- ☐ Red vessels on skin
- ☐ Aging skin
- ☐ Large pores
- ☐ Scars

**Neck**
- ☐ Crepey skin texture
- ☐ Vertical neck bands

**Chest**
- ☐ Brown Spots
- ☐ Lines and wrinkles

**Hands**
- ☐ Prominent veins and tendons
- ☐ Brown Spots
- ☐ Thin Skin

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# Consent to Communicate

Patient Name: _____

We would love to stay in touch, please mark the ways that you consent to us communicating with you:

| Method | Ok to Leave Voicemail | Ok to Leave Message with Another Person | Preferred Contact Method(s) | Best Time to Call* |
|---|---|---|---|---|
| ☐ Call Work Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ | |
| ☐ Call Cell Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ | |
| ☐ Call Home Phone | ☐Yes ☐No | ☐Yes ☐No | ☐ | |
| ☐ Send Email | - | - | ☐ | - |
| ☐ Email Appt Reminders | | | | |
| ☐ Email Medical Info | | | | |
| ☐ Email Marketing Info i.e: injection day specials, etc. | | | | |
| **Don't miss out on our quarterly phone sales! Enjoy specials on injectables, products, and all aesthetic treatments for one day only. You can prepay and save on your treatments to use later. Follow us on social media for updates on upcoming specials and events! *@sgkaesthetics* | | | | |
| ☐ Send Regular Mail | - | - | ☐ | - |
| Mail to which Address: ☐ Home ☐ Other (please list): | | | | |
| ☐ Send Text Page | - | - | ☐ | - |
| ☐ Text Appt Reminders – if so, list cell carrier: | | | | |
| ☐ Text Marketing Info i.e: injection day promotions reminders, etc. | | | | |

If it is ok to leave a message with another person, please list them:

| Name | DOB | Relationship | OK to Release Results? |
|---|---|---|---|
| | | | ☐Yes ☐No |
| | | | ☐Yes ☐No |

| **Alle/Aspire Registration: The Alle/Aspire programs allows you to earn points for eligible Allergan/Galderma treatments/products you receive from SGK Plastic Surgery. These points are redeemable for dollars off future eligible Allergan/Galderma treatment/products.** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Are you currently enrolled with Alle or Aspire? | ☐ | Yes | ☐ | No | Would you like to? | ☐ | Yes | ☐ No |

Signature: _____ Date: _____

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# HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____