Hessler Wellness

Traverse City

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Advance Beneficiary Notice (ABN)

Patient Name: _____ D.O.B: _____

The purpose of this form is to help you make an informed choice on your healthcare. You may or may not want to receive our services knowing that you are responsible in full for services rendered.

Be advised that you will not be reimbursed for this healthcare service. Gregory H. Hessler M.D. does NOT participate with insurance plans including Medicare, Blue Cross Blue Shield Products, Priority Health, or any other insurance plans for this office.

This office is a Functional Medicine Practice. It is not a Primary Care Office. This practice is not associated with any other offices where Dr. Hessler may or may not be in network for other types of healthcare services.

You are willingly accepting these services knowing that Dr. Hessler is an out-of-network provider. You agree not to submit this service claim to any insurance companies including Medicare, Blue Cross Blue Shield, etc.

Consultation fee:

I understand that my insurance company cannot be billed. I understand that I am financially responsible for services rendered today.

Patient Signature: _____ Date: _____

Female (Pre-Menopause)/Hormone Imbalance Symptoms

Patient Name: _____Date: _____

Date of Birth: _____

Please circle any/all of the following symptoms that apply to you

Acne
Fatigue/Tired All The Time
Low Blood Sugar
Shakiness/Weakness Episodes
Vaginal Odor
Mood Swings
Irritability
Insomnia
Anxiety
Hair Growth on Face, Breasts, or Abdomen
Body Aches or Aching Limbs
Urinary Tract Infections
Weird Dreams
Vaginal Itching
Lower Back Pain
Burping
Flatulence/Gas
Indigestion
Trouble Concentrating or Being Attentive
Nausea
Hair Loss

Frequent Urination
Snoring
Sore Breasts
Palpitations
Breast Lump(s)
Numbness or Tingling
Dizzy Spells/Vertigo
Panic Attacks
Skin Feeling Crawly
Migraine Headaches
Memory Lapses
Weight Gain
Frequent or Infrequent Menstrual Periods
Heavy Menstrual Periods
Premenstrual Bloating
Premenstrual Irritability or Mood Swings
Spotting Between Periods
Hungry All the Time
Soda Pop Consumption (Please indicate average per day/week)

Menstrual History

Patient Name: _____Date: _____

Date of Birth: _____

Please answer the questions as completely and accurately as you can

1. Are you menstruating? **YES** **NO**

2. Are your menstrual cycles regular? **YES** **NO**
   (Within 3 days variation per cycle)

3. How many periods have you had in the last 12 months?

   1-3 **4-8** **9-12**

4. Does your menstrual period last longer than 7 days? **YES** **NO**

5. Do you bleed or spot between periods? **YES** **NO**

6. Have you been pregnant? **YES** **NO**

7. Have you used or are you using birth control pills? **YES** **NO**

If Yes, Name:_____ Duration of Use:_____

8. Do you experience vaginal or yeast infections more than 4 times per year?

   YES **NO**

Female Menopause/Hormone Imbalance Symptoms

Patient Name: _____Date: _____

Date of Birth: _____

Please circle any/all of the following symptoms that apply to you

Hot Flashes
Night Sweats
Vaginal Dryness
Vaginal Odor
Mood Swings
Irritability
Insomnia
Depression
Loss of Sexual Interest
Hair Growth on Face
Painful Intercourse
Urinary Tract Infection
Weird Dreams
Lower Back Pain
Bloated
Flatulence/Gas
Indigestion

Osteoporosis
Hair Loss
Frequent Urination
Snoring
Sore Breasts
Heart Palpitations
Bloating
Urinary Leakage
Aching Wrists, Heels, Ankles, Shoulders or Knees
Panic Attacks
Skin Feeling Crawly
Migraine Headaches
Memory Impairment
Anxiety/Nervousness
Weight Gain
Lack of Energy/Tired

Weakness
Dry Skin
Sleepiness
Muscle Aching
Slow Speech
Swelling Eyelids or Face
Coarseness of Hair
Constipation
Shortness of Breath
Loss of Appetite
Cold Hands/Feet
Intolerance of Cold
Swelling Feet/Ankles
Diminished Taste
Diminished Hearing
Bleeding and Spotting

Date of Last Pap smear/Pelvic/Breast Exam:_____

Male Hormone Imbalance Symptoms

Patient Name: _____Date: _____

Date of Birth: _____

Please circle any/all of the following symptoms that apply to you

Nervousness
Irritability
Insomnia
Depression
Antisocial Tendencies
Crying Spells
Suicidal Tendencies
Inability to Concentrate
Hot flashes
Chilliness
Sweating
Palpitations
Increased Pulse Rate
Headache
Weakness
Fatigue
Muscle Pain

Nausea and Vomiting
Constipation
Weight Loss
Decreased Force with Urination
Urinary Frequency
Urinary Hesitancy
Diminished Libido
Decreased Erections
Heigh Loss
Enjoy Life Less
Deterioration in Your Ability to Play Sports
Fall Asleep After Dinner
Recent Decrease in Work Performance
Dry Skin
Sleepiness

Slow Speech
Heart Palpitations
Swelling of Eyelids
Thick Tongue
Swelling of Face
Coarsness of Hair
Paleness
Memory Impairment
Weight Gain
Losing Hair
Pale Lips
Shortness of Breath
Swelling Feet, Hands, or Ankles
Loss of Appetite
Diminished Hearing
Diminshed Taste

Date of Last Prostate/Rectal Exam:_____