In-depth Functional Medicine / Hormone Form
for Central Family Practice

Thank you for contacting Central Family Practice for an appointment.

While we are a general primary care office, several of our practitioners have specific areas of interest.
Since we do not rely on insurance reimbursement, we have the luxury of spending more time with you to listen and think of the body as an entire system, with all of the pieces acting together. We believe in standard medical practices, as well as complementary and alternative therapies, so we use an integrative approach.

Having a detailed history of your medical problems and symptoms can help us schedule you with the most appropriate practitioner who can help you put the pieces of the puzzle together. It is important that we have adequate time for your first visit to gather as much information as possible to help determine our initial plan. It is also important to have regular follow-up appointments to evaluate your progress, review test results with you, answer your questions and determine the next steps of treatment. Our visit fees reflect the time spent (outside your appointment time) reviewing your records, test results and researching and determining your treatment plan as well as the need to pay our overhead costs and the salaries of our wonderful staff. We will try to respect your time, hard-earned money and energy in this process. If you are ready to work together to improve your health, please read the next sections which cover boring details such as costs and paperwork.

While we don't accept insurance, we will provide you with a detailed bill including medical billing codes, and many patients submit this to their insurance for possible reimbursement. If you have an HSA or FSA fund, this money can be used for your visits. If you have concerns about the costs of tests, medications, etc., we can help you determine the most efficient approach. If you have insurance, it can be used for regular lab tests. If you do not have insurance, our office offers cash pricing through Quest Laboratories. Sometimes we utilize specialty labs and these tests are typically not covered by insurance. If you attempt to use your insurance for specialty testing, you may end up paying 2-3 times the cash price, so we recommend simply paying the cash price for these tests. Visit fees are based on medical billing codes which take into account the time spent during the visit as well as the complexity (whether or not we order labs, reviewing past medical records, medical decision making and the number of problems addressed). Please note: Our schedulers can provide you with a range of costs for follow-up visits, but they will not always be able to provide you with an exact fee. If the complexity of the visit is greater than what the schedule anticipated, the visit fee may be greater than what you were originally quoted.

In order to maximize our time in the office, it is helpful for us to review your information ahead of time. Please return the forms listed below to our office. Once we review the information and determine which practitioner will be the best fit for your needs, our staff will contact you to schedule your appointment and notify you of the price of the initial visit. The range for initial visits is $775-$950. Half of the visit fee will be required to schedule the appointment since we spend time reviewing your information and entering your history into our system before the appointment. The balance will be due at the time of your visit. Please expect 2-4 longer initial visits to thoroughly evaluate your case and determine the initial treatment plan. Once your condition is stable, many issues can be managed with shorter visits. Follow-up visit prices initially are $370-450 and then $190-370 for shorter visits. Specialty test costs range from $100-500. (prices subject to change)

Please complete and return the following forms:
--In-depth Patient History Form (the rest of this document)
--General Registration (if you are a new patient)
--Copies of ALL tests sent to forms@centralfamilypractice.com (labs, x-rays, MRIs, etc) that are pertinent to your concerns. We can only address tests that have been received at least 48 hours prior to your visit. General labs done in the last 6-12 months are very useful, as are food allergy tests, stool tests, urine organic tests, genetic tests. If you aren't sure if it is important, go ahead and include it. If you do not have copies, please fill out the Medical Records IN form on the website so we can request these from another provider.

Central Family Practice 720
W . 34th Street, Suite 105
Austin, TX 78705
512.371.9260

Patient Registration

Please print

Date: _____ DOB: _____ Age: _____ Sex: M F

Legal Name: _____
Last First Middle

Preferred Prounouns _____

Preferred Name: _____

Address: _____
Apt#

_____
City State Zip code

Phone: _____ _____
(Primary: Home Work Cell) (Secondary: Home Work Cell)

Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

List any Medication Allergies: _____

Household members currently living with you:

Name	Age	Relationship	Health Status

How did you hear about Central Family Practice? _____

In-Depth Patient History for Central Family Practice

Name:_____ _____ _____ DOB 12/06/2023 Are you visiting with
(First) (Last) (Preferred Name) Sex: M F Dr. Pugh or Dr. Ziedonis

Please list your current symptoms/concerns:

Please stop here and continue on last page if more space is needed.

Past Medical History – Please check if you currently have, or have a significant history of the following (brief details are all that are needed, we will clarify questions at your visit):

General: Chronic fatigue Intermittent fatigue Weight gain Weight Loss How many pounds?_____
Fevers Chills Night Sweats Trouble going to sleep Trouble staying asleep Daytime drowsiness

Eyes: Glaucoma Dry eye Uveitis Episcleritis Cataracts Surgery and dates:_____
Other eye issues:

Allergies: Seasonal Year-round Hives Aspirin allergy Latex allergy Nasal polyps Mold exposure
Medication allergies:
Food allergies:

Heart: Chest pain Heart racing Irregular heartbeat Trouble breathing when lying down High cholesterol
High blood pressure Heart murmur Heart attack Stent Stroke Varicose veins Blood clots
Other heart issues:

Lungs: Shortness of breath Chronic cough Chronic sputum (phlegm) Dry cough Pneumonia
Frequent bronchitis COPD/emphysema Exposure to tuberculosis Exposure to Asbestos
Asthma: Childhood Chronic Occasional Ever hospitalized? Y N Ever intubated? Y N
Currently use inhaler or other asthma med? Y N If so, what brand(s):
Other Lung issues:

GI: Abdominal pain: Left Right Upper Lower Middle Cramping Vomiting Bloating Loose stool
Watery stool Hard stool Clay-colored stool Bloody stool Mucous in stool Excessive gas Burping
Acid reflux/heartburn Trouble swallowing Stool urgency Intestinal infection/parasite Celiac disease
Irritable bowel syndrome Crohn's disease Ulcerative Colitis Gallbladder problems: surgery? Y N
Have you had an endoscopy? Yes No Date_____ Have you had a colonoscopy? Yes No Date_____
How often are your bowel movements? #_____per day week Hemorrhoids
Other stomach issues:

Kidneys/bladder: Burning with urination Difficult to urinate Chronic urine frequency Chronic bladder pain
Blood in urine Urine urgency Kidney stone Frequent urine infections: #_____ per year
Other kidney/bladder:

Skin: Frequent rashes Itching Psoriasis Rosacea Eczema Frequent boils/abscesses Nail problems
Skin cancer? Type:_____When:_____ Skin Cancer screening? Yes No Date:_____
Other Skin:

Name:_____ Date of birth:_____

Musculoskeletal: Joint pain Joint stiffness Joint swelling Joint redness Hot joints Muscle pain
Bone pain Muscle fatigue Muscle cramps Muscle twitches Muscle weakness Osteoporosis/Osteopenia
Osteoarthritis (general wear and tear) Rheumatoid arthritis Gout Lupus
Other musculoskeletal:

Neurological: Headaches (if frequent, please complete headache history form) Numbness Tingling
Vision problems Hearing problems Memory problems Foggy headed MS Epilepsy
Other neurological disease:

Endocrine: Diabetes Hypothyroid Hashimoto's Hyperthyroid/Graves Adrenal problem Intolerant to cold
Intolerant to heat Always thirsty Always hungry Crave sweets Crave salt

Blood/lymph: Swollen lymph glands Easy Bruising Anemia Platelet disorder Blood clot
Infections: HIV Hepatitis A B C Syphilis Gonorrhea Chlamydia Herpes: Cold sores Genital
Chicken pox Shingles Mono/Epstein Barr Chronic yeast infections HPV/Genital warts
Cancer (where/when?): _____ Positive TB Skin Test Exposure to HIV

Psych: Depression Anxiety Panic attacks Bipolar Schizophrenia Ever hospitalized? Y N
History of sexual abuse History of physical abuse History of mental/emotional/other abuse Alcoholism Stress

Men: Trouble getting erection Trouble maintaining erection Low sex drive Nighttime urination
Length of time with current sexual partner: _____

Women: Irregular periods Heavy Periods Painful Periods PMS Menopause/Perimenopause Last menstrual period: _____
Number of times pregnant: ____ Miscarriages/abortions: ____ Number of live births: ____ Number of still births: ____
Breast pain Discharge from nipples Breast lump (undiagnosed) Vaginal pain Vaginal Discharge
Vaginal itching Hot flashes Vaginal dryness Low sex drive
Date of last: Pap:_____ Mammogram: _____ Bone density: _____
Hysterectomy: uterus only/uterus and ovaries removed Reason:_____
Period length (days): _____ Usual interval between periods (days): _____ Age of first intercourse: _____ Age of first period:
Infection: ovary or fallopian tube Ovarian cyst Abnormal pap smear DES exposure Currently trying to get pregnant
Difficulty achieving orgasm Length of time with current sexual partner: _____

Which of the following contraceptive methods have you used: (please circle)

IUD Diaphragm Foam Other _____
Birth control pills Vasectomy None, same sex preference
Condoms Tubal ligation Natural family planning
None

Hormonal Symptoms:
For women - Please rate all that apply from 1-10, with #1 being barely noticeable to #10 being unendurable.

Abdominal bloating _____
Allergies _____
Anxiety _____
Angry _____
Appetite increase _____
Appetite decrease _____
Bleeding and spotting (not menses) _____
Breast tenderness and swelling _____
Craving sweets and starches _____
Craving salt and fat _____
Craving (other) specific _____
Constipation _____ Crying _____
Depression or sadness _____
Diarrhea _____

Fatigue _____
Headaches _____
Heavy menstrual bleeding _____
Hot flashes _____
Irritable _____
Insomnia _____
Menstrual cramps _____
Moody _____
Nausea _____
Night sweats _____
Sexual pleasure/arousal (inc/dec) _____
Swelling _____
Trouble concentrating/remembering _____
Vaginal dryness _____

Name:_____ Date of birth:_____

Surgeries: Tonsillectomy Adenoidectomy Appendectomy Gallbladder removal (cholecystectomy)
Thyroid surgery: Partial Full
Other:

Any other conditions not listed?

Childhood history:

Any problems at birth or in childhood? (surgeries, infections, birth defects)
Did you have antibiotics more than 3 times in childhood? Yes No

Social history:

Alcohol intake: None <5 drinks per year <5 drinks per month <7 drinks per week
7--14 drinks per week >14 drinks per week Are you concerned about your drinking?
Smoking/Tobacco: Current smoker/tobacco user? Yes No Type: Cigarettes E Cig Smokeless
If yes, how many per day? Interested in quitting? Yes No
Past smoker? Yes No Year started using: _____ Year Quit: _____
Any use of the following? Marijuana Cocaine IV drugs Inappropriate prescription use Other:_____
Do you exercise? Yes No How many times per week? _____ Activities:_____
Are you exposed to any toxins at home, work or during hobbies? _____ Mold exposure
Anything we need to know about stress, home situation, etc?

Diet:

Do you follow any particular diet? Vegetarian Vegan Pescatarian Gluten Free Dairy Free Other:_____
Do you: Drink Milk Drink soy milk Drink Almond Milk Eat soy Eat sugar/sweets often
Do you cook? Yes No Are you open to trying diet changes? Yes No
Do you avoid any foods for religious or other reasons?
How often do you eat out? Number of days per week_____
How many fruits/vegetables do you have per day? _____
Do you drink soda? Yes No If yes, # per week: _____ Regular or Diet sodas _____
Do you have a history of eating disorder or unhealthy eating habits? Yes No
Do you have problems with any particular foods? (List food and reaction)
Are you concerned about your eating habits? Yes No
Do you consider your diet healthy? Yes No
Are you having problems with over-eating? Yes No

Name:_____ Date of birth:_____

Family History: Please list any known medical conditions for each family member. All things are important, but be sure to include cancers (including type), heart attacks (age it occurred, stents, bypass surgery, etc.), strokes, diabetes, blood clots, autoimmune diseases, genetic diseases, mental health issues, etc. A detailed history is useful (if known), so please use back if more space needed. If deceased, please state so and list age of death.

Mom: Dad:

Brother(s): Sister(s):

Maternal grandmother: Paternal grandmother:

Maternal grandfather: Paternal grandfather:

Aunts/uncles: Aunts/uncles:

If you see any specialists on a regular basis (cardiologist, allergist, etc.) please list their name and specialty:

We often recommend vitamins and other supplements in my treatment recommendations. Supplements are not regulated by the FDA, and can vary between manufacturers. We believe that good quality supplements can augment other treatments and can sometimes treat conditions for which we do not have prescription options. Are you open to the use of supplements in your treatment? (Circle One)

Definitely, I prefer them to prescriptions Yes, whatever is best Maybe No, they make expensive urine

Name:_____ Date of birth: 02/27/2024

Medications/supplements: Please list all prescription and non-prescription medications. OK to list on separate page if needed, but please include all information. No need to list dose of combination supplements. Make note of any specific information (brand needed, etc.). Also list medications that you take as needed (headache medication, allergy medication, etc.)

Name (For supplements, list name and manufacturer)	Dose	Number of pills	Times per day

If you take a lot of supplements, it is most helpful if you bring the actual bottles to your appointment so we can look at all of the ingredient lists together to avoid duplication

Name: _____ **Date of Birth:** _____

Additional information: