Diana Hoppe, M.D.
OB/GYN & Women's Health Specialist

Welcome!

My name is Dr. Diana Hoppe and I want to be the first to welcome you to my center for Women's Health. I specialize in Women's health, including hormones, perimenopause, teenage & adult health and sexuality, health and nutrition and overall restoration of your authentic beauty and wellbeing using both science and alternative medicine.

In this New Patient Package, you will have the opportunity to tell me about yourself, set a few goals and share with me what you would like to accomplish during your visit with me.

I have chosen to be an out-of-network provider simply because our relationship is special. Women are unique and each patient should be treated based upon her lifestyle, body type and goals, not by insurance providers. You and I will co-create a health care plan that suits your vision of how you want to live your life.

During our visit expect to be greeted by my staff Angie and Cynthia and escorted to your own private room for your visit. During that time, I will review the information you completed below, discuss any concerns, fears and goals you have, provide you with strategies and education to prevent illness and disease and prepare a treatment plan to optimize your health and natural beauty.

Until we meet, I wish you the best of health and inner peace!

* 20+ years of experience in Women's Health
* Author of "Health Sex Drive, Healthy You"
* Awarded "Best Published Inspiration Book" 2010
* Guest appearance on Dr. Oz T.V. Show
* Contributor to Vogue Magazine, Women's Health & Fitness and Fit Pregnancy
* **Awarded as one of "San Diego's Best Doctors" in 2016 & 2005**

Dr. Diana

Dr. Diana Hoppe

317 N. El Camino Real, Suite #310 Encinitas, CA 92024
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About Dr. Hoppe & Our Center

Our Mission:
To restore women's natural beauty, health and wellbeing so they can experience inner peace and happiness.

Our Culture:
Our patients experience the most caring safe haven for healing, transformation and wellness care. We believe patients deserve to have an abundance of resources available to them in order to reach their health care goals in an environment they can call their "2nd Home."

Our Treatment:
Every woman is unique and special. We individualize treatment plans and wellness care to restore your health and create balance using science and personalized "interactive patient education" to empower women.

Our Staff:
We call our staff team members. It's not a job to them, it's their purpose and passion to be fully present and prepared for each patient.

Cynthia M.
Office Manager
& Patient Care Advocate

Kelly B.
Medical Assistant
& Patient Care Advocate

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Patient Testimonials (as seen on Yelp)

Dr. Hoppe has been my ObGyn for "umteen" years now! I have referred many friends and clients to her. I have never gotten poor feedback from anyone, only glorifying comments. Dr. Hoppe is a unique woman. She can communicate in a caring and understanding way, "person-to-person" without the typical doctor babble. She is more of an integrated physician who looks at health from the well-studied and very intelligent physician that she is, and also in a holistic manner. She looks at many ways of healing. She is a magnificent woman in so many ways. She has a sense of humor, a sensitive heart and you immediately feel you can trust her. I feel so honored to know her and have her for my physician!

AND YES, I DRIVE FROM REDLANDS TO SEE HER!

Paula F, Redlands CA

Went to Dr. Hoppe today for the first time....LOVED HER!!! She is very thorough and very easy to talk to. I would recommend her to anyone...even a guy;;)! She really is a God send...my search for a new Doctor is over!!!

Heather H, Carlsbad CA

Dr. Hoppe is wonderful! I would never see anyone else.

She is warm and welcoming, and always spends ample time addressing my concerns and needs. I have never felt rushed or uncomfortable while in her office, and I have always left feeling high-spirited and well taken care of. I cannot impress enough how positive my visits have been over the past year.

Her office is intimate and classy, with a small, friendly staff. Also important, I would recommend her for women of *all* ages, from young to mature and everyone else in between.

A true gem!

Kimberley C, Carlsbad, CA

My wish has finally come true!!!! After visiting 8 (yes, honestly 8!!) different doctors in North County, Palm Springs & San Diego area, I have finally found THE ONE!!! And, I'm beyond thrilled!!!!!!! Dr Hoppe is an incredibly bright doctor with years of knowledge AND is also an all-around personable & great chic!

My search is OVER!

I love absolutely everything about this office! The receptionist is adorable & even made me a cup of delicious coffee. The nurse is a total delight. And Dr. Hoppe was total perfection and I'm picky!!!
If you're not going to be baking any more buns in your oven, I promise.... Dr. Hoppe is the lady to see!!!!! Amazing!!!

From here on out....she's my girl!!!

Amelia R, San Diego, CA

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Patient Demographics

Name: _____ DOB: ____/____/____ Age: _____ Today's Date:_____

Address: _____
Street *City* *State* *Zip*

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

E-Mail: _____
* You will receive Dr Hoppe's Newsletter and valuable medical info

Primary Care Physician: _____Phone: (____) _____

Pharmacy Name/Location: _____Phone: (____) _____

Emergency Contact/Relation: _____ Phone: (____) _____

Who may we thank for referring you to our office? _____

LABORATORY/ANCILLARY SERVICE FEES: Ancillary facilities and/or laboratories will bill you (or your insurance company if applicable) for any services they render. These facilities may or may not be contracting providers with your insurance company. **Medicare patients: Labs MAY not covered if ordered by Dr Hoppe.**
IF YOUR INSURANCE COMPANY REQUIRES THE USE OF SPECIFIC FACILITIES, LET THE MEDICAL ASSITANT KNOW. We will make every effort to send your specimen to the appropriate facility. In the event that this is not possible, you will be responsible for any and all ancillary/laboratory fees. You will be notified of all test results within 2 weeks. If you have not received your results within 2 weeks, please call the office.

Please provide a phone number where you can be reached during the day, (____) _____. In the event you are not available, may we leave a detailed message at this number? **Y/N** **Initials**_____

Payment is expected at time of visit.

I understand that payment for services rendered to me by Diana Hoppe, M.D. is my responsibility and is due at the time services are rendered, and that Dr. Hoppe is a **non-contracted healthcare** provider with my insurance company. I also understand it is my responsibility to submit a claim to my insurance if I choose to do so. Dr Hoppe can supply a superbill for patient claim submittal **Initial**_____

Cancellation Policy

As a courtesy, we do ask that you give us 24 hrs notice prior to your appointment. There will be a **$50 fee for no show or less than a 24 hr notice of cancelation**.

I agree with cancelation policy **Initials:** _____

Patient Signature: _____ **Date:** _____

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date : _____

Print Patient Name: _____

Patient/Guardian Signature: _____

Relationship to Patient: _____

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MENSTRUAL HISTORY

First day of last period _____

Age of first period _____

Do You Have:	Yes	No
Pain with periods?	___	___
Bleeding between periods	___	___

Intervals ? Every _____ days Duration? ___Days

Period is: Light ___ Moderate ___ Clots ____?

DO YOU HAVE ANY OF THE FOLLOWING BEFORE OR DURING YOUR PERIODS?	Yes	No
Cramps	___	___
Nervous tension	___	___
Mood swings/ Irritability	___	___
Anxiety	___	___
Weight Gain	___	___
Breast tenderness	___	___

GYNECOLOGICAL HISTORY

Date of last Pap smear _____

Where was it done? _____

	Yes	No
Was it normal?	___	___
Any history of abnormal PAPs?	___	___
Did your mother take D.E.S. while pregnant with you?	___	___

HAVE YOU EVER HAD? SEXUALLY TRANSMITTED DISEASES (STDS)	Yes	No
Gonorrhea	___	___
Syphilis	___	___
Chlamydia	___	___
Genital Herpes	___	___
Genital Warts	___	___
VAGINAL INFECTIONS:		
Trichomonas	___	___
Yeast (monilia)	___	___
Gardnerella	___	___
UTERINE ABNORMALITIES:		
Infection of the tubes/ uterus	___	___
Uterine Fibroids	___	___
Ovarian Cysts	___	___
Endometriosis	___	___
Cervicitis	___	___
CANCER OF:		
Ovaries	___	___
Vulva	___	___
Vagina	___	___
Uterus	___	___
Breast	___	___

Name: _____

Date of Birth: _____

PERSONAL MEDICAL HISTORY

HAVE YOU EVER HAD:	Yes	No
Eye problems	___	___
Diabetes	___	___
Thyroid problems	___	___
Cancer	___	___
Heart Disease	___	___
Breast disease/ mass	___	___
Stroke	___	___
Anemia	___	___
Bladder or Kidney disease	___	___
Depression	___	___
Epilepsy	___	___
Gallbladder disease	___	___
High Blood pressure	___	___
Liver Disease/ Hepatitis	___	___
Thrombophlebitis	___	___
Migraines	___	___
Blood vessel clots	___	___
Lung disease	___	___
Rubella/ Immunization	___	___

SEXUAL HISTORY

Age of first intercourse _____

Answer the following:	Yes	No
Are you currently sexually active?	___	___
Partner with painful urination?	___	___
Have you had a new partner in the last two months?	___	___
Do you have pain during intercourse?	___	___
Bleeding/ spotting during intercourse?	___	___
Do you practice anal sex?	___	___

Frequency of sex/ week? _____

OBSTETRICAL HISTORY

NUMBER OF:	
Pregnancies	_____
Abortions	_____
Premature births	_____
Still Births	_____
Living children	_____
Neonatal deaths	_____
Miscarriages	_____
Ectopic pregnancies	_____
Molar Pregnancies	_____

Complications of pregnancies and/or deliveries_____

_____

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Name:_____ **Date of Birth**_____

CONTRACEPTIVE HISTORY

WHICH BIRTH CONTOL METHODS HAVE YOU USED:	Yes	No
Abstinence	___	___
Pill	___	___
IUD	___	___
Diaphragm	___	___
Condom	___	___
Foam/ other Spermicides	___	___
Rhythm	___	___
Natural Family Planning	___	___
Fertility Awareness	___	___
Vasectomy	___	___
Tubal ligation	___	___
Depo Provera (injection)	___	___
Withdrawal	___	___
Other Method	___	___
None	___	___

Problems _____
_____
Side Effects _____
_____
Failures/ Reasons _____
_____
Current method of contraception: _____
_____

	Yes	No
Do you have any allergies?	___	___
Are you on any medications?	___	___

Do you have any problem with medications that you would like to discuss? _____

HOSPITALIZATION AND SURGICAL HISTORY	Yes	No
Hospitalizations	___	___
Surgeries	___	___

HABITS	Yes	No
Do you smoke cigarettes?	___	___
Consume alcoholic beverages?	___	___
Do you use illegal drugs?	___	___

FAMILY MEDICAL HISTORY

	YES	NO	WHO
Cancer	___	___	_____
Diabetes	___	___	_____
Heart Disease	___	___	_____
Stroke	___	___	_____
Sickle cell anemia	___	___	_____
Alcoholism	___	___	_____
Tuberculosis	___	___	_____
Inherited genetic disease	___	___	_____
Mental Retardation		___	_____
Tay Sachs disease	___	___	_____
Down syndrome	___	___	_____
PKU	___	___	_____
High blood pressure	___	___	_____

Last Mammogram: _____

Last Colonoscopy: _____

List ALL Medications: (dosage and times per day)
_____
_____
_____
_____
_____
_____

List Allergies:
_____
_____

REASON, WHEN?
_____
_____

HOW MANY, WHAT TYPE?
_____
_____

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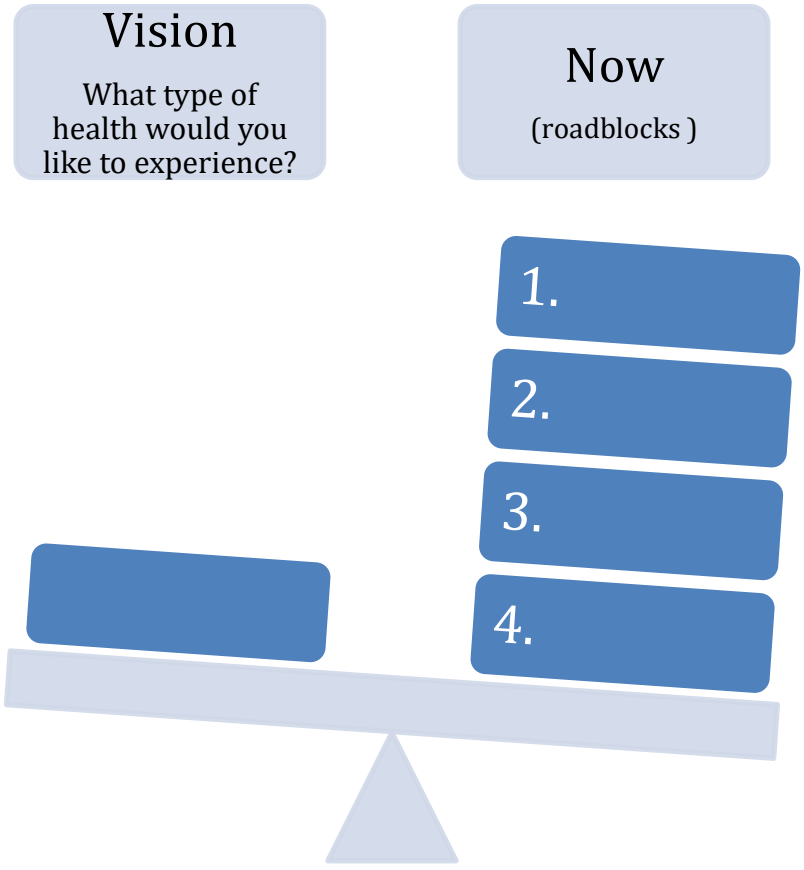
Health and Wellness Goals: For:_____

My top 3-wellness/health care goals are: (ex: eat healthy, reduce stress)

1. _____
2. _____
3. _____

The 4 Roadblocks which always seem to get in the way are of achieving my goals are:



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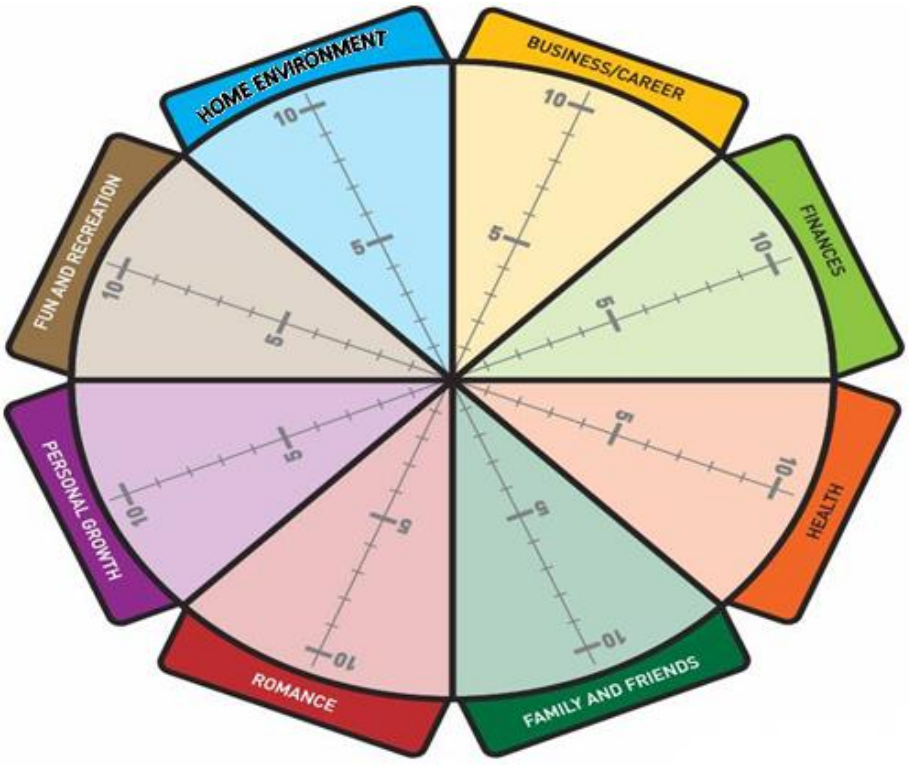
The Wheel of Life: Finding Balance in a busy life:

Let's take a bird's eye view of your life – as it is, right now. **Yes, your life as it is today.** Not where you want it to be – but how it really is. Take a few moments to reflect on your life and fill in the specific areas listed on the wheel.

How do you feel about your business/career? If you feel like it's almost perfect mark a 9 or 10. If you feel like your business career is lacking/in need of help, rate it a 1-2. **10 is the highest, 1 is the lowest.** How are you finances right now? Feel secure and happy with your finances, rate high – if not, rate low.

Work/Home environment reflect how you feel about your workplace and your home environment.



Dr. Hoppe NOTES!

Name: _____

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