PATIENT INFORMATION SHEET

PATIENT INFORMATION:

PATIENT NAME:_____ DATE OF BIRTH:_____

AGE:_____ SS#_____ MARITAL STATUS: M S D W SEX: M F

RACE:_____ PREFERRED LANGUAGE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME:_____ CELL:_____ WK:_____

EMAIL:_____ PLACE OF EMPLOYMENT:_____

HOW DID YOU HEAR ABOUT US: TV NEWSPAPER BILLBOARD INTERNET FRIEND/FAMILY:_____

OTHER:_____

EMERGENCY CONTACT:_____ PHONE:_____

RELATIONSHIP:_____

REFERRING / FAMILY PHYSICIAN INFORMATION:

REFERRING / FAMILY PHYSICIAN:_____ PHONE:_____

CITY:_____ STATE:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____

ID#:_____ GROUP#:_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____ SUBSCRIBER'S SEX: M F

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

RELATIONSHIP TO PATIENT:_____ ADDRESS:_____ CITY_____ STATE_____ ZIP____

SECONDARY INSURANCE COMPANY:_____

ID#:_____ GROUP#:_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____ SUBSCRIBER'S SEX: M F

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

RELATIONSHIP TO PATIENT:_____ ADDRESS:_____ CITY_____ STATE_____ ZIP____

INSURANCE IS NOT GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.

FINANCIAL AGREEMENT

"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE:_____ **DATE:**_____

Male Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

DateofBirth:_____ Age:_____ Weight:_____ Occupation:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

_____

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name	Signature	Today's Date

BHRT CHECKLIST FOR MEN

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		