MALE PATIENT QUESTIONNAIRE & HISTORY

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Age: _____ Weight: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to the individual below about your treatment. By giving the information below you are giving us permission to speak with the individual about your treatment.

Name: _____ Relationship: _____

Cell Phone: _____

SOCIAL

◯ I am sexually active **OR** ◯ I want to be sexually active **OR** ◯ I do not want to be sexually active

◯ I have completed my family **OR** ◯ I have NOT completed my family

◯ My sex life has suffered **OR** ◯ I have not been able to have an orgasm or it is difficult

HABITS

◯ I smoke cigarettes or cigars _____ per day. ◯ I use e-cigarettes _____ a day.

◯ I drink alcoholic beverages _____ per week. ◯ I drink more than 10 alcoholic beverages a week.

◯ I use caffeine _____ a day.

DRUG ALLERGIES

Drug Allergies: _____

Have you ever had any issues with local anesthesia? ◯Yes ◯No Do you have a latex allergy? ◯Yes ◯No

Current Medications: _____

Current Hormone Replacement? ◯Yes ◯No If yes, what? _____

Past hormone replacement therapy: _____

MALE PATIENT QUESTIONNAIRE & HISTORY

FAMILY HISTORY

◯ Heart Disease ◯ Diabetes ◯ Osteoporosis ◯ Alzheimer's/Dementia ◯ Breast Cancer

◯ Other: _____

PERTINENT MEDICAL/SURGICAL HISTORY:

◯ Cancer (type):
Year: _____

◯ Elevated PSA

◯ Trouble passing urine

◯ Taking medicine for prostate or male-pattern balding

◯ History of anemia

◯ Vasectomy

◯ Erectile dysfunction

◯ Testicular or prostate cancer

◯ Prostate enlargement or BPH

◯ Kidney disease or decreased kidney function

◯ Frequent blood donations

◯ Non-cancerous testicular or prostate surgery

◯ Severe snoring

◯ Taking medicine for high cholesterol

BIRTH CONTROL METHOD

◯ None applicable

◯ None - planning pregnancy in the next year

◯ Depend on partner's contraception

◯ Vasectomy

◯ Condoms

◯ Other: _____

ACTIVITY LEVEL:

◯ Low - Sedentary

◯ Moderate - walk/jog/workout infrequently

◯ Average - walk/jog/workout 1 to 3 times per week

◯ High - walk/jog/workout regularly 4+ times per week

MEDICAL HISTORY

◯ High blood pressure or hypertension

◯ Heart disease

◯ Arterial fibrillation or other arrhythmia

◯ Blood clot and/or a pulmonary embolism

◯ Depression/anxiety

◯ Chronic liver disease (hepatitis, fatty liver, cirrhosis)

◯ Arthritis

◯ Hair thinning

◯ Sleep apnea

◯ Stroke and/or heart attack

◯ HIV or any type of hepatitis

◯ Hemochromatosis

◯ Psychiatric disorder

◯ Thyroid disease

◯ Diabetes

◯ Thyroid disease

◯ Lupus or other autoimmune disease

◯ Other: _____

MALE PATIENT HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark “none”.

SYMPTOMS	NONE 0	MILD 1	MODERATE 2	SEVERE 3	VERY SEVERE 4
Sweating (night sweats or excessive sweating)	○	○	○	○	○
Sleep problems (difficulty falling asleep , sleeping through the night or waking up too early)	○	○	○	○	○
Increased need for sleep or falls asleep easily after a meal	○	○	○	○	○
Depressive mood (feeling down, sad, lack of drive)	○	○	○	○	○
Anxiety (inner restlessness, feeling panicked, nervous, inner tension)	○	○	○	○	○
Physical exhaustion (decrease in muscle strength/endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	○	○	○	○	○
Sexual problems (change in desire or performance)	○	○	○	○	○
Bladder problems (difficulty urinating, increased need to urinate)	○	○	○	○	○
Erectile changes (weaker erections, loss of morning erections)	○	○	○	○	○
Joint and muscular symptoms (joint pain/swelling, muscle weakness, poor recovery after exercise)	○	○	○	○	○
Difficulties with memory	○	○	○	○	○
Problems with thinking, concentrating, or reasoning	○	○	○	○	○
Difficulty learning new things	○	○	○	○	○
Trouble thinking of the right word to describe persons, places or things when speaking	○	○	○	○	○
Increase in frequency or intensity of headaches/migraines	○	○	○	○	○
Rapid hair loss or thinning	○	○	○	○	○
Feel cold all the time or have cold hands/feet	○	○	○	○	○
Weight gain, increased belly fat or difficulty losing weight despite diet and exercise	○	○	○	○	○
Infrequent or absent ejaculations	○	○	○	○	○

Total Score _____

Severity Score: Mild : 1-20 / Moderate: 21-40 / Severe: 41-60 / Very Severe: 61-80

FEE ACKNOWLEDGEMENT

There is no guarantee reimbursement from insurances for Bio-Identical Hormone Replacement Therapy. You will be responsible for payment in full at the time of your BHRT procedure (see fee schedule below).

- New Patient Consultation Fee **$200**
- Female Hormone Pellet Insertion Fee **$450/$400 Returning**
- Male Hormone Pellet Insertion Fee **$950/$900 Returning**
- 6 Week initial post pellet follow up (in person/virtual) **$75**
- Non-Farmakeio Pharmacy Management Fee **$20**

Print Name:_____

Signature:_____ Date:_____

We accept the following forms of payment

American Express, Master Card, Visa, Discover, Checks, Cash*

HIPAA INFORMATION AND CONSENT FORM

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

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name: _____

Signature: _____ Date: _____