Male Patient Questionnaire & History

Hormone WELLNESS LLC
bioTE CERTIFIED PRACTITIONER (405) 620-0049

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: _____

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.
( ) 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**

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Male Symptom Checklist

Symptoms (please check mark)	**Never**	**Mild**	**Moderate**	**Severe**
Decline In General Well Being				
Fatigue				
Joint Pain & Muscle Aches				
Excessive Sweating				
Sleep Problems				
Increased Need For Sleep				
Irritability				
Nervousness or Anxiety				
Depressed Mood				
Exhaustion & Lacking Vitality				
Declining Mental Focus & Concentration				
Feeling You Have Passed Your Peak				
Feeling Burned Out				
Decreased Muscle Strength				
Weight Gain, Belly Fat or Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in Beard Growth				
New Migraine Headaches				
Decreased Sexual Desire or Libido				
Decreased Morning Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejaculations				
No Results From E.D. Medications				

I Smoke _____ Cigarettes or Cigars Per Day. I Drink _____ Alcoholic Beverages Per Week.

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy:_____

Nutritional Supplements/Vitamins:_____

Have You Ever Had Any Issues With Anesthesia (Y/N):____ Explain:_____

History of Prostate Cancer (Y/N):_____

I Am Sexually Active (Y/N) :_____

I Have Completed My Family (Y/N):_____

Medical Release Form

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Last Name: _____

First Name: _____ MI: _____

Address: _____

City/ST/Zip code: _____

Home Phone :(_____) _____-_____ ◯ Leave Message

Cell Phone: (_____) _____-_____ ◯ Leave Message

Work Phone: (_____) _____-_____ext:_____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Sex: Male O Female O

Marital Status: Married: ____ Divorced: _____ Single: ___
Widowed:_____

Social Security: _____-_____-_____ (**REQUIRED**)

Driver's License #: _____ State_____

Race: American Indian or Alaska Native O Asian O
Native Hawaiian O Hispanic O African American O
White O Other Race O
Ethnicity: Hispanic O Non-Hispanic O

Email: _____@_____

Pharmacy where you want your prescriptions sent:

Pharmacy Name: _____

Address: _____

How did you hear about us?

_____

Primary Insurance Policyholder:

Name: _____

DOB: ____/____/_____ SSN: _____-_____-_____

Group ID #: _____ Individual ID #: _____

Secondary Insurance: _____

Policyholder

Name: _____

DOB: ____/____/_____ SSN: _____-_____-_____

Group ID #: _____

Individual ID #_____

Primary Care Physician: _____

Patient Consent for E-Prescribing (Electronic Prescribing):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative:

_____

Date: _____

Time: _____

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Laboratory

We ask that each patient know his/her insurance benefits, including your lab benefits, prior to your scheduled appointment time.

You will need to know how much your individual lab policy covers and which lab your insurance prefers you go to (DLO or Lab Corp). You have the option to send your lab through your insurance or you can choose to do self-pay through us. If you choose to send through your insurance you will be responsible for any co-insurance or deductible that applies. You will not receive a bill for lab work from Choctaw Women`s Clinic for your lab work, it will come from the lab itself.

If you choose self-pay, you pay us at date of service and you will not receive a bill from the labs.

Circle one: Insurance or Self-pay

_____ _____

Patient Signature Date

Choctaw Women's Clinic No Show and/or Cancellation Policy

Failure to CANCEL within a 24-hour time prior to your appointment time will result in a $35 fee.

Failure to NOT SHOW for an appointment will result in a $35 no show fee.

Choctaw Women's Clinic No Show and/or Cancellation Policy for Consultation or a Pellet Procedure
Failure to CANCEL a consultation or pellet procedure within a 24-hour time prior to your appointment time will result in a $50 fee.

Failure to NOT SHOW for a consultation or pellet procedure will result in a $50 no show fee.
I understand the above cancellation and no-show policy.

_____ _____

Signature Date

Medical Release Form

I, _____ hereby authorize the physician and staff of CWC permission to release information concerning my health and well-being to the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

O Leave message on answering machine - Phone Number: _____

O I DECLINE to authorize the release of information concerning my health and wellbeing.

The following information may be given to the above individuals: (please check all you agree to):
O Any other information (No limitation) includes all communication.
O Appointment Time O Test/Lab Results
O Procedures O Medications

The following items may be picked up on my behalf by the above individuals: (please check all you agree to):
O Written Prescriptions O Copy of Medical Recordsl
O Radiology Films O Laboratory Results
O Any other information regarding my health

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I understand that this organization originates and maintains health records describing my health history, symptoms, diagnoses, examinations, past/current/future treatments and test results as well as financial information pertaining to my account. I acknowledge that I have been provided with Full Disclosure of their Notice of Privacy Practices and I consent to the use and disclosure of my own or persons form whom I am responsible (i.e. minors) Financial and Health Information for any reason that Choctaw Womens Clinic may require to carry out Health care operations to or for me and/or for persons whom I am responsible.

Patient Signature: _____ Date: _____
(Parent/Guardian Signature if patient is a minor.).)

Witness Signature: _____ Date: _____

If this form is not filled out and/or signed by the patient or legal guardian, no information can be given regarding your medical care to any individual including spouse and/or family members. This includes copies of medical records, radiology films or prescriptions on your behalf. If you have any questions regarding this authorization, please ask the receptionist for additional information.