OC HEALTH

MALE PATIENT QUESTIONNAIRE & HISTORY

Name:_____ Date:_____

Date of birth:_____ Age:_____ Weight:_____ Occupation:_____

Home address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ Work:_____

Preferred contact number:_____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address:_____ May we contact you via email? ☐ 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 means you have 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.

Name:_____ Relationship:_____

Home phone:_____ Cell phone:_____ Work:_____

Social:

☐ I am sexually active OR ☐ I want to be sexually active. ☐ 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 very difficult

Habits:

☐ I smoke cigarettes or cigars _____ per day. ☐ I use e-cigarettes ____ a day. ☐ I use caffeine ____ a day.

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

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

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

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

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 dysfunctio
☐ 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:

☐ Not 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

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial 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
- ☐ High cholesterol
- ☐ 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 _____

Review of Systems

Constitutional Symptoms: ☐ Fever ☐ Night sweats ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Eyes: ☐ Blurred vision ☐ Double vision ☐ Eye discharge

HEENT: ☐ Hearing loss ☐ Ringing in ears ☐ Dizziness ☐ Vertigo ☐ Nose bleeds ☐ Bleeding gums ☐ Lack of taste or smell ☐ Sinusitis

Respiratory: ☐ Chronic cough ☐ Coughing up blood ☐ Wheezing ☐ Shortness of breath

Cardiovascular: ☐ Chest pain ☐ Irregular heartbeat ☐ Palpitations ☐ Swelling (feet, ankles, hands)

Gastrointestinal: ☐ Loss of appetite ☐ Blood in stools ☐ Nausea ☐ Vomiting Reflux ☐ Rectal bleeding ☐ Abdominal pain

Genitourinary: ☐ Urinary urgency ☐ Urinary frequency ☐ Blood in urine ☐ Painful urination ☐ Gas ☐ Episodic skin rashes

Integumentary: ☐ Skin rash ☐ Itching ☐ Change in skin color ☐ Change in hair or nails

Musculoskeletal: ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Back pain ☐ Neck pain ☐ Cold extremities

Endocrine: ☐ Heat or cold intolerance ☐ Excessive thirst or urination ☐ Change in hat or glove size

Hematologic / Lymphatic: ☐ Enlarged nodes or glands ☐ Bleeding tendency ☐ Anemia

Psychiatric: ☐ Anxiety ☐ Low Mood ☐ Fear ☐ Panic Attacks

Neurological: ☐ Headache ☐ Weakness ☐ Stiffness ☐ Numbness ☐ Seizures ☐ Tingling ☐ Difficulty chewing ☐ Choking ☐ Tremors ☐ Difficulty walking ☐ Falls ☐ Confusion ☐ Trouble concentrating ☐ Snoring

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Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Sexual Desire or Performance (reduced or diminished)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss, rapid or thinning	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take

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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 that identifies a patient's condition or information that 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: _____

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Name: _____ Date of birth: _____

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

The hormones used in the pellets are made at a compounding pharmacy. Compounding drugs, as defined by the FDA, is "the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. The FDA does not approve these individualized compounded medications. In most cases, insurance does not cover bioidentical compounded pellets.

We require payment at the time of service and, if you choose, we will provide a form to send to your insurance company with a receipt that you paid out of pocket. This form and receipt serve as evidence of your treatment. Our office does not submit these forms to your insurance company.

For patients who have access to a Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. Please request the receipt and paperwork to submit for reimbursement if needed.

New Patient Office Fee $125.00
Includes Initial Consultation and Telehealth Follow-Up Appointment

Male Hormone Pellet Insertion Fee $800.00

Testosterone Injections . . . . . $150 per month

We accept the following forms of payment: Visa, Mastercard, Checks and Cash

Print Name: _____

Signature : _____