Address and Contact Information

Name: _____ Date of Birth: _____

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 smoke cigarettes or cigars___ per day. ☐ I use caffeine___ per day. ☐ I use e-cigarettes___per day.

☐ I have completed my family. ☐ My partner and I would like to have more children in the near future.

☐ I have no biological children. If this is true, have you tried to have children? ☐ Yes ☐ No

If you have not had children, have you had prior semen analysis? ☐ Yes ☐ No

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Family History:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's or dementia ☐ Prostate cancer

Medication & Other Pertinent Information

Any known 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 Testosterone Replacement? ☐ Yes ☐ No If yes, are you on estrogen blocker? ☐ Yes ☐ No

Past Testosterone Replacement Therapy: _____

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

Other Medical Conditions:

☐ High blood pressure or hypertension
☐ Heart disease
☐ Atrial fibrillation or other arrhythmia
☐ Blood clot and/or a pulmonary emboli
☐ Depression/anxiety
☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
☐ Taking Proscar (finasteride), Flomax (Tamsulosin) or Avodart (dutasteride)
☐ 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 _____

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MALE 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	Never (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)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or 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 or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

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

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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 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.

Print Name: _____

Signature: _____

Date: _____