

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Cell Phone: _____ Home Phone: _____

Is it OK to leave a message on your voicemail with relevant clinical information? Yes No

Occupation: _____ Employer: _____

Ethnicity: Please check all boxes that apply.

<input type="checkbox"/> Hispanic	<input type="checkbox"/> Caucasian	<input type="checkbox"/> African-American	<input type="checkbox"/> Asian	<input type="checkbox"/> Other: (please list)
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Health Insurance

Insurance Company: _____

Policy Holders Name: _____

Policy ID#: _____ Group #: _____

Clinical Reminders

You may choose to be contacted via text or email with important clinical reminders. You will not receive spam messages. Please mark the appropriate box to indicate your preference. Cell service provider info is needed for text reminders.

Text: Please list your cell service provider:
Please list your preferred cell number:

Email: Please print email address:

Text & Email: Please complete Text and Email information directly above this line.

Please Do Not Contact Me

How did you hear about us?

<input type="checkbox"/> Internet/Vital4men Website	<input type="checkbox"/> 98.7 FM Sports Radio	<input type="checkbox"/> Doctor Referral (please list)
<input type="checkbox"/> 100.7 FM KSLX Classic Rock	<input type="checkbox"/> 620 AM ESPN Sports Radio	<input type="checkbox"/> Friend Referral (please list)
<input type="checkbox"/> 92.3 FM News Radio	<input type="checkbox"/> Sign	<input type="checkbox"/> Other (please list)

Release of Medical Information

Per HIPAA regulations, personal medical information cannot be disclosed to any individual not listed below.
I _____, give permission for my health care information to be disclosed for the purposes of communicating results and findings to the family members listed below.

<u>Name of Authorized Individuals</u>	<u>Relationship to Patient</u>	<u>DOB (for security)</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

_____	_____	_____
Printed Name	Signature	Today's Date

Cancer Risk Assessment Questionnaire

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Your Personal & Family History is Important to Us

We NEED this information to perform an accurate assessment of your medical & cancer risks

Instructions: *When you circle Y, provide the age of diagnosis and relationship of family member with the illness/cancer.*

Please include all relatives up to your great-grandparents (including siblings, aunts / uncles, cousins, nieces / nephews, grandparents)

Are you of Ashkenazi Jewish (Eastern European Descent) – Important for genetic screening Y / N

Have you ever been tested for a Hereditary Cancer Syndrome (e.g. BRCA or Lynch Syndrome) Y / N

If Yes, please specify: _____

MEDICAL & CANCER HISTORY Please <u>list every relative</u> who has had one of the following conditions		SELF	FAMILY MEMBER	
			MOTHER'S SIDE AGE at Diagnosis	FATHER'S SIDE AGE at Diagnosis
Y	N	<i>EXAMPLE:</i> Breast Cancer	Aunt - age 45 Cousin - age 61	Grandmother - age 53
Y	N	Breast Cancer		
Y	N	Anyone with Breast Cancer in both breasts or in the same breast 2x (list ages at time of diagnosis)		
Y	N	Male Breast Cancer at any age		
Y	N	Triple Negative Breast Cancer (ER-, PR-, HER2-)		
Y	N	Ovarian Cancer		
Y	N	Prostate Cancer		
Y	N	Pancreatic Cancer		
Y	N	Colon Cancer		
Y	N	Endometrial Cancer		
Y	N	Any other Cancers (please list with as much detail as possible)		

Patient Signature _____ Date _____ MD Signature _____ Date _____

Knowing your family history can save your life!
Use your next family gathering to actively collect and share family history with your relatives.

ViTal4Men Clinic



HIPAA – Notice of Privacy Practices

The Vital4Men Clinic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Summary of Rights and Obligations Concerning Health Information.

Vital4Men Clinic is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Vital4Men. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Disclosure of Your Health Care Information:

We may disclose your healthcare information as necessary to comply with State Workers Compensation laws, Public Health Authorities, Emergency Situations, Judicial & Administrative Proceedings, Law Enforcement, Medical Examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude for referrals, and change of ownership.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations.

Print Name

Signature

____/____/____

Date



Financial Agreement

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

Payment for Services:

You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover.

If your insurance carrier's "Criteria" for Testosterone Replacement Therapy does not cover or restricts coverage for services provided by Vital4Men, you will be responsible to arrange payment for the specific services that are not covered. We are under contract with your insurance carrier to bill only for services that fall under the "Criteria" of covered benefits. We cannot bill for services that are deemed "experimental". In some cases Testosterone Replacement Therapy is considered "experimental" by specific insurance companies if the strict "Criteria" is not met.

LAB BILLING: Please be aware that Vital4men has no role in or control over billing issues related to clinical laboratory fees. If you have questions about bills received for laboratory charges or insurance coverage available to you, please contact the clinical laboratory in question and/or your insurance carrier. We regret that our billing staff cannot be of assistance to you in mitigating laboratory charge issues. Please understand that we cannot know which tests are covered by your individual insurance. We also cannot be responsible when you and/or your employer choose a high deductible insurance plan. Our interest is in providing you with quality medical care, utilizing appropriate laboratory testing.

Current policies in the "ACA" Affordable Care Act may delay payment of your claims due to non-payment of policy premiums by the patient. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our "Financial Policy" guidelines.

I understand that, if my account is referred to a collection specialist due to non-payment, I will pay any applicable collection fees.

INITIALS:

_____ I HAVE READ THIS FINANCIAL AGREEMENT, ASKED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS.

Patient (Printed)

Patient (Signature)

Date

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____	Date of Birth: _____	Today's Date: _____
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Please tell us the REASON FOR TODAY'S VISIT or any concerns you would like to discuss with your doctor today.

CURRENT MEDICATIONS

Please list ALL your current PRESCRIPTION and NON-PRESCRIPTION medications, including SUPPLEMENTS and VITAMINS.

Medication Name	Strength (ie, mg/pill)	How Taken (ie, 2 tablets twice per day)

ALLERGIES

Please list ALL known ALLERGIES (drugs, latex, food, animals, bee stings, etc).

Allergy	Reaction (ie, rash, nausea, difficulty breathing)

IMMUNIZATIONS

Vaccination	Date	Vaccination	Date
<input type="checkbox"/> Influenza (flu shot)		<input type="checkbox"/> Measles, Mumps, Rubella (MMR)	
<input type="checkbox"/> Pneumococcal (pneumonia)		<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Tetanus (Td)		<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Tetanus with Pertussis (Tdap)		<input type="checkbox"/> Human Papilloma Virus (HPV)	
<input type="checkbox"/> Shingles		<input type="checkbox"/> Meningococcal (meningitis)	
<input type="checkbox"/> Varicella (chicken pox) shot <i>or</i> illness		<input type="checkbox"/> Tuberculosis (TB) skin test	

HEALTH MAINTENANCE

Exam	Date	Exam	Date
<input type="checkbox"/> Physical Exam		<input type="checkbox"/> EKG	
<input type="checkbox"/> Recent Labs		<input type="checkbox"/> Echocardiogram	
<input type="checkbox"/> Lipid Panel		<input type="checkbox"/> Cardiac Stress Test	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> EYE Exam	
<input type="checkbox"/> DEXA Scan (bone density)		<input type="checkbox"/> FOBT (stool card for hidden blood)	

HEALTH HISTORY QUESTIONNAIRE

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Name: _____ Date of Birth: _____ Today's Date: _____

MEDICAL HISTORY

Please mark the appropriate boxes to indicate if you have ever experienced the following conditions, with year of onset/diagnosis.

Neurology

- Stroke (CVA) _____
- Transient Ischemic Attack (TIA) _____
- Seizures/Epilepsy _____
- Dementia _____
- Parkinson's _____
- Migraine _____

Urinary

- Enlarged Prostate _____
- Prostate Cancer _____
- Kidney Stones _____
- Kidney Failure _____
- Dialysis _____

Blood

- Anemia _____
- Leukemia _____
- Lymphoma _____
- Bleeding Disorder _____
- Blood Transfusion _____
- HIV/AIDS _____

Endocrine

- Thyroid Disorder _____
- Diabetes - Insulin _____
- Diabetes - Non-Insulin _____
- Elevated Cholesterol _____
- Osteoporosis _____

Gastrointestinal

- GERD or Reflux _____
- Irritable Bowel Syndrome _____
- Ulcerative Colitis _____
- Crohn's Disease _____
- Diverticulitis _____
- H. pylori _____
- Stomach Ulcer _____
- Pancreatitis _____
- Cirrhosis _____
- Hepatitis B _____
- Hepatitis C _____
- Colon Polyps _____
- Colon Cancer _____
- Barrett's Esophagus _____
- Lactose Intolerance _____
- Celiac Sprue _____
- Hiatal Hernia _____
- Hemorrhoids _____
- Gallbladder Disease _____

Psychiatric

- Anxiety Disorder _____
- Depressive Disorder _____
- Bipolar Disorder _____
- Schizophrenia _____

Cardiac

- Heart Attack _____
- Coronary Artery Disease _____
- Angina or Frequent Chest Pain _____
- High Blood Pressure _____
- Congestive Heart Failure _____
- Irregular Heart Beat _____
- Heart Murmur _____
- Rheumatic Fever _____

Circulation

- Deep Vein Thrombosis _____
- Pulmonary Embolism _____
- Peripheral Vascular Disease _____
- Carotid Artery Disease _____

Lungs

- Asthma _____
- COPD (emphysema) _____
- Sleep apnea _____
- Valley Fever _____
- Tuberculosis _____

Rheumatology

- Osteoarthritis _____
- Gout _____
- Fibromyalgia _____
- Rheumatoid Arthritis _____
- Lupus _____

Cancer

- Cancer (list type)

Any Condition not Listed

- Other (please list)

SURGICAL HISTORY

Please mark the appropriate boxes to indicate any SURGERIES or PROCEDURES you have had, with date/year.

- Angioplasty _____
- Angioplasty with stent _____
- CABG (heart bypass) _____
- Heart valve _____
- Pacemaker _____
- Defibrillator _____
- Carotid artery _____
- Aortic aneurysm _____
- Knee arthroscopy _____
- Knee replacement _____
- Hip replacement _____
- Back surgery _____
- ORIF (repair of broken bone) _____
- Tonsillectomy _____
- Appendectomy _____
- Hernia repair _____

- Thyroid surgery _____
- Cholecystectomy (gallbladder) _____
- Gastric bypass _____
- Colectomy (colon removed) _____
- Colostomy _____
- Small bowel resection _____
- Liver biopsy _____
- Hemorrhoid surgery _____
- Cataract _____
- LASIK _____
- Carpal tunnel release _____
- Other (please list) _____

Gender Specific Male:

- Vasectomy _____
- Prostate biopsy _____
- Prostatectomy _____
- TURP _____

Gender Specific Female:

- Breast biopsy _____
- Mastectomy _____
- Breast augmentation _____
- Breast reduction _____
- Hysterectomy _____
- Bilateral tubal ligation _____
- D & C _____
- C-section _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____	Date of Birth: _____	Today's Date: _____
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SOCIAL HISTORY

Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Union					
Do you have children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many?	Male(s)	Female(s)	
Occupation	Employer					
Exercise	Regular Exercise is any planned physical activity (ie, brisk walking, aerobics, jogging, bicycling, weight training, swimming, rowing, etc.) performed to increase physical fitness. Such activity should be performed 4 to 5 times per week for 20-60 minutes per session. Exercise does not have to be painful to be effective but should be done at a level that increases your breathing rate and causes you to break a sweat. Please choose one of the following options based on this definition.					
	<input type="checkbox"/> Sedentary (No exercise)					
	<input type="checkbox"/> Mild Exercise (ie, walk 3 blocks, golf, etc., doesn't require increased breathing rate and sweating)					
	<input type="checkbox"/> Occasional Exercise (ie, same definition as Regular Exercise but only 1 to 3 times per week)					
Diet	Do you follow a specified diet? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If yes, please indicate <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Other (please list)					
	How many meals do you eat in an average day?					
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> Energy Drinks					
	If yes, how many caffeinated drinks do you have in an average day?					
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor					
	If yes, how many alcoholic drinks do you have in an average week?					
Tobacco	<input type="checkbox"/> Never smoked					
	Current smoker: packs/day _____ # of years _____			<input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipe		
	Former smoker: packs/day _____ # of years _____ quit date _____					
	Current chewing tobacco: # of years _____					
Drugs	Do you currently use recreational drugs? If yes, please describe use on the next line. <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Do you have a history of recreation drug use? If yes, please describe on the next line. <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Have you ever used testosterone or any other anabolic steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If you have used testosterone or any other anabolics, was it prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If you have used testosterone or any other anabolics, please list types and dates of use on the next line.					
Sex	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

MEDICAL PROVIDERS

Please list all doctors that provide medical care to you, indicating field of medical specialty (primary care, cardiology, gastroenterology, endocrinology, urology, psychiatry, etc.)

Medical Provider	Medical Specialty
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of Birth: _____ Today's Date: _____

FAMILY MEDICAL HISTORY					
<input type="checkbox"/> Adopted If you are adopted and you do <u>not</u> know your family medical history you may skip the rest of the Family Medical History section.					
	Mother	Father	Sister(s) # /	Brother(s) # /	Other, list relation:
Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grandmother, Grandfather, Aunt, Uncle, Son, Daughter
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Age at death if deceased	_____	_____	_____	_____	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAD (Coronary Artery Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHF (Congestive Heart Failure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IBD (Crohn's Disease, Ulcerative Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PVD (Peripheral Vascular Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal (Kidney) Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of Birth: _____ Today's Date: _____

GENERAL REVIEW OF SYSTEMS

Please mark the appropriate boxes to indicate any CURRENT symptoms.

- Skin
- Head/Neck
- Eyes
- Ears
- Nose
- Throat
- Respiratory
- Chest/Heart
- Back
- Bowel/Intestinal
- Bladder
- Musculoskeletal
- Psychologic

TRT SPECIFIC SYMPTOMS

Please mark the appropriate boxes to indicate any CURRENT symptoms, or symptoms that have improved while on TRT.

- Fatigue/decrease in energy level.
- Unintentional weight gain, _____ lbs in _____ months.
- Unintentional weight loss, _____ lbs in _____ months.
- Difficulty falling asleep or staying asleep.
- Decreased libido.
- Difficulty with erection or erectile dysfunction.
- Decrease in strength/increase in recovery time/decrease in exercise capacity.
- Waking up at night to urinate. If box is checked, how many times per night? _____
- Pain or burning with urination.
- Blood in your urine.
- Difficulty emptying your bladder completely.
- Depressed mood.
- Stress or feelings of anxiety.
- Irritability or moodiness.
- Decreased mental focus.
- Decrease in sense of well being.
- Other

HEALTH HISTORY QUESTIONNAIRE

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Name: _____	Date of Birth: _____	Today's Date: _____
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TRT SPECIFIC MEDICAL HISTORY & REVIEW OF SYSTEMS

Please mark the appropriate boxes to indicate if YOU or a FAMILY MEMBER have EVER been FORMALLY diagnosed by a medical provider with any of the following conditions.

	SELF	BLOOD RELATIVE (list relation if applicable)
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease (CAD)	<input type="checkbox"/>	<input type="checkbox"/>
History of Blood Clot(s)	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
BPH (enlarged prostate, formally diagnosed)	<input type="checkbox"/>	
Current Tobacco Use	<input type="checkbox"/>	

Please mark the appropriate boxes to indicate if you have ever experienced the following conditions or medical evaluations.

<input type="checkbox"/> History of kidney, bladder or prostate infections.	
<input type="checkbox"/> History of testicular trauma.	If box is checked, please explain.
<input type="checkbox"/> History of head trauma.	If box is checked, please explain.
<input type="checkbox"/> History of referral to a Cardiologist.	If box is checked, please explain.
<input type="checkbox"/> History of prostate exam.	If box is checked, what was the date?

Vital4Men Clinic



**Vital4Men Clinic
Testosterone Consent Form & Terms of Acceptance**

At the Vital4Men Clinic, our goal is to help treat hypogonadism (low testosterone) and restore your testosterone to an optimal level, as well as improve your overall quality of life. The American Academy of Family Physicians has examined the effectiveness & safety of testosterone replacement therapy (TRT) and found that there is no compelling evidence of major side effects of properly administered TRT. Side effects can be controlled and may include, but are not limited to:

Injection Site Reaction: Localized irritation, swelling, warmth or redness of surrounding skin.

Fluid Retention: Fluid accumulation may be observed, especially in older men. Symptoms may include leg or ankle swelling, worsening of congestive heart failure, or high blood pressure.

Elevation in Red Blood Cells/Hemoglobin/Hematocrit: TRT may cause an increase in red blood cell concentration, hemoglobin and/or hematocrit levels, which may increase cardiovascular and clotting risk. This may require therapeutic phlebotomy or blood donation.

Breast Tissue Enlargement: This is the result of testosterone converting into estrogen, and may require dosage adjustments and/or medication to prevent conversion to estrogen.

Prostate Enlargement: From conversion of testosterone to DHT. No current study has linked TRT to increased incidence of prostate cancer.

Changes in Lipid & Cholesterol Levels

Acne and/or Oily Skin

Testicular Atrophy: From decreased LH & FSH signal from pituitary.

Decreased Fertility: From decreased FSH signal from pituitary.

_____ All of the above conditions have been fully disclosed & explained by
(patient initial) my Vital4Men Provider.

_____ I have had the opportunity to discuss in detail my health history with
(patient initial) my Vital4Men Provider.

_____ I understand that Vital4Men recommends an annual physical
(patient initial) examination.

_____ I understand that medicine is an art, not an exact science and that
(patient initial) diagnosis and treatment may involve injury or risks.

Print Name

Signature

____/____/____
Date

B12 Injections Informed Consent

Patient Name _____

Vitamin B-12 helps maintain good health and has been shown to be beneficial in helping to reduce stress and fatigue, improve memory and cardiovascular health, and maintain a good body weight. It can also assist the body in converting proteins, fats and carbohydrates into energy and is necessary for healthy skin and eyes.

All medications and supplements have potential side effects. Potential common B12 side effects include but are not limited to: mild diarrhea, upset stomach, nausea, a feeling of pain and/or warm sensation at the injection site, swelling, headache and joint pain.

1. If any of these side effects become severe or troublesome I will contact my physician immediately.
2. I understand that although rare, vitamin B12 injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking vitamin B12 injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of B12 injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects include: rapid heartbeat, chest pain, flushed face, muscle cramps and weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives, skin rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.
3. Before starting vitamin B12 injections I will make sure to tell my physician if I am pregnant, lactating, or have any of the following conditions: Leber's Disease, kidney disease, liver disease, an infection, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that has an effect on bone marrow, an allergy to cobalt or any other medication, vitamin, dye, food or preservative.
4. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non-prescription medications may result in side effects when they interact with the B12 injection.
5. B12/MIC is not recommended for patients with allergies to sulfa drugs. Caution is advised in those receiving B12 but have a suspected sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent B12 Injections. I agree to inform my physician of any health status changes. I hereby release the doctor, the person injecting the B12 and the facility from liability associated with this procedure.

Patient Signature _____ Date: _____