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.				
☐ Hispanic	☐ Caucasian	☐ African-American	☐ Asian	☐ Other: (please list)

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?		
☐ Internet/Vital4men Website	☐ 98.7 FM Sports Radio	☐ Doctor Referral (please list)
☐ 100.7 FM KSLX Classic Rock	☐ 620 AM ESPN Sports Radio	☐ Friend Referral (please list)
☐ 92.3 FM News Radio	☐ Sign	☐ 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 purposesof communicating results and findings to the family members listed below.

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

****

_____	_____	_____
Printed Name	Signature	Today's Date

viTal4men.com
Testosterone Replacement Therapy

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 list every relative 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	*EXAMPLE:* 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

ViTal4Men Clinic

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:**_____

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
☐ Influenza (flu shot)		☐ Measles, Mumps, Rubella (MMR)	
☐ Pneumococcal (pneumonia)		☐ Hepatitis A	
☐ Tetanus (Td)		☐ Hepatitis B	
☐ Tetanus with Pertussis (Tdap)		☐ Human Papilloma Virus (HPV)	
☐ Shingles		☐ Meningococcal (meningitis)	
☐ Varicella (chicken pox) shot *or* illness		☐ Tuberculosis (TB) skin test	

HEALTH MAINTENANCE

Exam	Date	Exam	Date
☐ Physical Exam		☐ EKG	
☐ Recent Labs		☐ Echocardiogram	
☐ Lipid Panel		☐ Cardiac Stress Test	
☐ Colonoscopy		☐ EYE Exam	
☐ DEXA Scan (bone density)		☐ FOBT (stool card for hidden blood)	

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:**_____

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_____

Endocrine
- ☐ Thyroid Disorder_____
- ☐ Diabetes - Insulin_____
- ☐ Diabetes - Non-Insulin_____
- ☐ Elevated Cholesterol_____
- ☐ Osteoporosis_____

Cardiac
- ☐ Heart Attack_____
- ☐ Coronary Artery Disease_____
- ☐ Angina or Frequent Chest Pain_____
- ☐ High Blood Pressure_____
- ☐ Congestive Heart Failure_____
- ☐ Irregular Heart Beat_____
- ☐ Heart Murmur_____
- ☐ Rheumatic Fever_____

Lungs
- ☐ Asthma_____
- ☐ COPD (emphysema)_____
- ☐ Sleep apnea_____
- ☐ Valley Fever_____
- ☐ Tuberculosis_____

Urinary
- ☐ Enlarged Prostate_____
- ☐ Prostate Cancer_____
- ☐ Kidney Stones_____
- ☐ Kidney Failure_____
- ☐ Dialysis_____

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_____

Rheumatology
- ☐ Osteoarthritis_____
- ☐ Gout_____
- ☐ Fibromyalgia_____
- ☐ Rheumatoid Arthritis_____
- ☐ Lupus_____

Blood
- ☐ Anemia_____
- ☐ Leukemia_____
- ☐ Lymphoma_____
- ☐ Bleeding Disorder_____
- ☐ Blood Transfusion_____
- ☐ HIV/AIDS_____

Psychiatric
- ☐ Anxiety Disorder_____
- ☐ Depressive Disorder_____
- ☐ Bipolar Disorder_____
- ☐ Schizophrenia_____

Circulation
- ☐ Deep Vein Thrombosis_____
- ☐ Pulmonary Embolism_____
- ☐ Peripheral Vascular Disease_____
- ☐ Carotid Artery Disease_____

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:**_____

SOCIAL HISTORY

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	☐ Civil Union
Do you have children?	☐ Yes	☐ 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.				
	☐ Sedentary (No exercise)				
	☐ Mild Exercise (ie, walk 3 blocks, golf, etc., doesn't require increased breathing rate and sweating)				
	☐ Occasional Exercise (ie, same definition as Regular Exercise but only 1 to 3 times per week)				
	☐ Regular Exercise				
Diet	Do you follow a specified diet?			☐ Yes	☐ No
	If yes, please indicate	☐ Vegetarian	☐ Vegan	☐ Other (please list)	
	How many meals do you eat in an average day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	☐ Energy Drinks
	If yes, how many caffeinated drinks do you have in an average day?				
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	☐ Beer	☐ Wine	☐ Liquor
	If yes, how many alcoholic drinks do you have in an average week?				
Tobacco	☐ Never smoked				
	☐ Current smoker: packs/day_____ # of years_____			☐ cigarettes	☐ cigars	☐ pipe
	☐ Former smoker: packs/day_____ # of years_____ quit date_____				
	☐ Current chewing tobacco: # of years_____				
	☐ Former chewing tobacco: # of years_____ quit date_____				
Drugs	Do you currently use recreational drugs? If yes, please describe use on the next line.			☐ Yes	☐ No
	Do you have a history of recreation drug use? If yes, please describe on the next line.			☐ Yes	☐ No
	Have you ever used testosterone or any other anabolic steroids?			☐ Yes	☐ No
	If you have used testosterone or any other anabolics, was it prescribed by a doctor?			☐ Yes	☐ 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?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ 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

☐ Adopted If you are adopted and you do not 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:	Grandmother, Grandfather, Aunt, Uncle, Son, Daughter
Living	☐	☐	☐	☐		
Deceased	☐	☐	☐	☐		
Age at death if deceased	____	____	____	____		
Alcoholism	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	
Alzheimer's Disease	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	
Blood Disease	☐	☐	☐	☐	☐	
CAD (Coronary Artery Disease)	☐	☐	☐	☐	☐	
Cancer, Type _____	☐	☐	☐	☐	☐	
CHF (Congestive Heart Failure)	☐	☐	☐	☐	☐	
COPD/ Emphysema	☐	☐	☐	☐	☐	
CVA (Stroke)	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	
Developmental Delay	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Eczema	☐	☐	☐	☐	☐	
Hearing Deficiency	☐	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	
IBD (Crohn's Disease, Ulcerative Colitis)	☐	☐	☐	☐	☐	
Learning Disability	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	☐	
Osteoarthritis	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	
PVD (Peripheral Vascular Disease)	☐	☐	☐	☐	☐	
Renal (Kidney) Disease	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

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:**_____

REVIEW OF SYSTEMS

Please mark the appropriate boxes to indicate any CURRENT symptoms.

Constitutional
- ☐ Fatigue/Decrease in energy
- ☐ Unintentional Weight Gain of _____ lbs
- ☐ Unintentional Weight Loss of _____ lbs
- ☐ Insomnia
- ☐ Fever
- ☐ Chills
- ☐ Loss of Appetite
- ☐ Other_____

Neurological
- ☐ Headache
- ☐ Dizziness or Vertigo
- ☐ Memory Loss
- ☐ Numbness or Tingling
- ☐ Tremors
- ☐ Other_____

Endocrine
- ☐ Excessive Thirst
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Other_____

Eyes/Ears/Nose/Throat/Mouth
- ☐ Vision Changes
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Neck or Jaw Pain
- ☐ Lumps in Neck
- ☐ Other_____

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain or Pressure
- ☐ Palpitations
- ☐ Shortness of Breath with Exercise
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Leg Cramping
- ☐ Other_____

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Coughing up Blood
- ☐ Sputum
- ☐ Snoring
- ☐ Other_____

Genitourinary
- ☐ Incontinence
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Urge to Urinate
- ☐ Urine Retention
- ☐ Blood in Urine
- ☐ Dark Urine
- ☐ Awaking to Urinate
- ☐ Discharge
- ☐ Change in Urine Stream
- ☐ Lumps in Testicles
- ☐ Menstrual Problems
- ☐ Menopause
- ☐ Other_____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn or Indigestion
- ☐ Difficulty Swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Other_____

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Muscle Aches
- ☐ Other_____

Integumentary
- ☐ Rash
- ☐ Change in Moles
- ☐ Other_____

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Other_____

Psychologic
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Other_____