viTal4men.com
Testosterone Replacement Therapy

Patient Form

Testosterone Replacement Therapy

STEP 1: FILL OUT YOUR FORM

You can begin filling out this form in your browser or download it to your computer and then fill it out.

OPTION 1

FILL OUT IN YOUR BROWSER, THEN DOWNLOAD

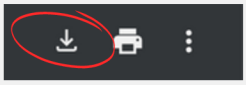
- Be sure to not close or refresh your browser, doing so will erase your information.
- Once you've completed filling it out, you will need to download it.
- Use the instructions in Option 2 to download your form.

OPTION 2

DOWNLOAD TO YOUR COMPUTER, THEN FILL OUT

- To download to your computer click on the download button, as shown below.

SAFARI



CHROME

STEP 2: SUBMIT YOUR FORM

Download your form, follow the instructions above to do so.

Click the "Submit Form" button below. This will open up your email and attached your patient form. You can also manually email the completed PDF as an attachment

SUBMIT FORM >

or email to: info@vital4men.com

Select Your Location ◯ Chandler ◯ Mesa/Gilbert ◯ Peoria

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._____	_____	_____

****

Patient 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 ☐ Yes ☐ No

Have you ever been tested for a Hereditary Cancer Syndrome (e.g. BRCA or Lynch Syndrome) ☐ Yes ☐ No

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	Y/N	Aunt - age 45 Cousin - age 61	Grandmother - age 53
☐	☐	Breast Cancer			
☐	☐	Anyone with Breast Cancer in both breasts or in the same breast 2x (list ages at time of diagnosis)			
☐	☐	Male Breast Cancer at any age			
☐	☐	Triple Negative Breast Cancer (ER-, PR-, HER2-)			
☐	☐	Ovarian Cancer			
☐	☐	Prostate Cancer			
☐	☐	Pancreatic Cancer			
☐	☐	Colon Cancer			
☐	☐	Endometrial Cancer			
☐	☐	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.

_____ ___/___/___

Patient 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 (Signature) Date

ADVANCED BENEFICIARY NOTICE

Date:_____

Patient Name:_____ Date of Birth:_____

Your insurance: _____ has created strict guidelines regarding testosterone therapy. Based upon these strict guidelines, the following scenarios may apply to you:

1. **Vital4Men may not be permitted to bill the codes for some of the testosterone therapy related services you received during your visit to your insurance carrier because the insurance company's testosterone therapy policy prohibits Vital4Men from doing so.**

2. **Vital4Men is permitted to bill your insurance for all codes related to the testosterone therapy you received during your visit. The insurance company considers some of the services or procedures performed experimental. These "experimental procedures" are not usually a benefit and may not be paid by your insurance company.**

This "Advanced Beneficiary Notice" is to notify you that if any services are denied as "experimental procedures" the cost of the services may be the responsibility of the patient. You will be informed by one of our staff members if this applies to you. An amount that you will pay at the time of each visit for these non-covered procedures will be confirmed and communicated to you. If your insurance changes or is terminated, please notify our staff immediately. Any insurance changes may affect the agreed upon amount you will pay per visit. You will be notified of any changes prior to your next visit.

The codes that may be denied may include but are not limited to: 96372, J1071, J3420_____

A copy of these guidelines is available through your insurance company. Each insurance company differs in their testosterone therapy policy. If you have further question regarding your insurance policy, please contact the customer service number on the back of your insurance card.

The charges for these codes will be approximately: $ 5.00 to $ 175.00

Signature of Patient:_____

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:_____

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

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

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

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	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Heart Attack	☐	☐
Coronary Artery Disease (CAD)	☐	☐
History of Blood Clot(s)	☐	☐
Prostate Cancer	☐	☐
BPH (enlarged prostate, formally diagnosed)	☐	
Current Tobacco Use	☐	

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

☐ History of kidney, bladder or prostate infections.	
☐ History of testicular trauma.	If box is checked, please explain.
☐ History of head trauma.	If box is checked, please explain.
☐ History of referral to a Cardiologist.	If box is checked, please explain.
☐ History of prostate exam.	If box is checked, what was the date?

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.

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

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

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

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

_____ Patient 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: _____