Vital Flow PLLC

Penny Ingram, APRN

Men's Intake Form

Patient Name: _____ Date: _____

Address:_____DOB_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormone Replacement (BHRT) is? _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement, and that it is not our intention to go against your physician's advice. Do you understand that this is a cash pay practice, Medicare cannot be billed.

What are your goals for Biologically Identical Hormone Replacement?

_____

Medical History

Family History **(relationship)** **(relationship)**

Cancer (type) _____ _____ Heart Disease_____ _____

Diabetes _____ _____ High B/P _____ _____

Other _____ _____

Personal History

- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Smoking _____
- ☐ _____
- ☐ Stroke
- ☐ Adult Mumps
- ☐ Prostate Operation
- ☐ Vasectomy _____
- ☐
- ☐ Cancer(type) _____
- ☐ Persistent Urinary Tract Infections
- ☐ Other Testicular Problems
- ☐ Orchitis
- ☐

Cholesterol Serum:_____ Triglycerides:____ HDL:____ LDL:____ Chol/HDL ratio:_____ Date:_____

Date of Last Prostate Exam: _____ PSA Results: _____Current Health Care Provider/s:_____

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ Do you exercise, describe:_____

Surgery: **Date of Surgery:**

- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____

To what degree do you experience the following, scale 0-5 (0=never 5=daily/frequently)

	1st appt	2nd appt	3rd appt	4th appt	5th appt
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Impotence / Decreased erections					
Inability to ejaculate					
Dry skin on face or hands					
Weight gain / Increased Abdominal Fat					
Backache, joint pain or stiffness					
Loss of muscle mass/tone					
Decreased Urine Flow					
Increased Urinary Urge					
Sleep Disturbances					
Decreased Libido					
Thinning Hair					
Bone Loss					
Night Sweats					
Brain Fog/ Burned out Feeling					
Decreased Stamina					

Current Medications & Reason:

_____

_____

Current Vitamins / Minerals / Herbal Formulas:

_____

Prior Hormone Replacement Therapy History: (include dates of use)

_____

Alcohol/amount per day/week:_____

Allergies (drug, food, pollen):_____ Caffeine/amt per day_____ Men: BHRT considerations, it is recommended that baseline hormone levels be checked. This can be achieved by blood testing. Here are the typical tests:

- PSA
- testosterone (free & total)
- Vit. D 25-Hydroxy
- thyroid: TSH, free T3, and free T4
- Complete Blood Count
- Comprehensive Metabolic Panel.

If you have recently (2 to 3 months) had a blood, please attach the results to your questionnaire.

Notes and/or Questions:

_____

_____

Privacy Agreement

Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at Vital Flow PLLC. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____

Print Last Name Print First Name M.I.

_____ _____

Patient Signature (or authorized representative) Date