MALE PATIENT INFORMATION FORM

Last Name________________________ First Name _____________________Middle___________

Date of Birth ________/________/_________ Age_________ Sex: M / F Marital Status: M S D W

Email: ______________________________ Phone: Home: _______________ Cell: _____________________

Home Address: ____

City______________________________ State _________ Zip_______________

PREFERRED METHOD OF CONTACT? (please circle) Home Phone Cell Phone Email

Employer______________________________________Occupation___________________________

REASON FOR VISIT / MAIN CONCERN____

Primary Care Physician______________________ Date of Last Physical______________________

PRESCRIPTION MEDICATIONS *(PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)*

Medication	Dose and Frequency
1.	
2.	
3.	
4.	
5.	

NON PRESCRIPTION MEDICATIONS *(LIST OVER THE COUNTER, HERBAL, AND VITAMINS)*

1.	3.	5.
2.	4.	6.

DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS? NO_________YES_______

MED:________________________________ REACTION:___________________________________

MED:________________________________ REACTION:___________________________________

PLEASE LIST ANY ALLERGIES OR REACTIONS TO FOODS OR ENVIRONMENTAL SUBSTANCES?

____

Health History For Men

Lifestyle information: Answer the following questions with Yes or No and explain if necessary.

Are you concerned about aging? ☐Yes ☐No, Do you have a specific concern?_____________________

Are you concerned about appearance? ☐Yes ☐No, Have you had Aesthetic treatments?_____________

Are you concerned about memory loss? ☐Yes ☐No

Are you under a great deal of stress, now or recently? ☐Yes ☐No

Do you practice any form of stress reduction (Meditation, yoga, tai chi)? ☐Yes ☐No, _______________

Are you concerned about your weight? ☐Yes ☐No

Current Symptoms: Please mark any of the following that may apply.

☐Fatigue or lack of energy

☐Insomnia

☐Decreased or absent sex drive (libido)

☐Infrequent or absent ejaculations

☐Erectile issues

☐Declining mental ability and memory

☐Diminished strength and exercise tolerance

☐Joint ache/new onset of arthritic symptoms

☐Hair loss

☐Mental sluggishness and difficulty focusing

☐Cold all the time

☐Poor balance and coordination

☐Constipation

☐Stay up for over 24 hours

☐Dry and/or wrinkled skin

☐Change in mood, Anxiety/depression

☐Loss of spontaneous morning erections

☐Shrinking testicles

☐Breast development

☐No result from erectile dysfunction medications

☐Muscle shrinkage

☐Weight gain, belly fat

☐New headaches

☐ Feeling of hopelessness or no motivation

☐Swelling

☐ Brittle nails

☐Dry eyes

☐Height decreased, Osteoporosis or Osteopenia

☐Other ____

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Medical History: Please mark any of the following that may apply.

☐Any form of Hepatitis or HIV- Type____

☐Prostate cancer

☐Colon cancer

☐Other cancer ___________________________

☐Narcolepsy

☐Blood clot or clotting disorder

☐Heart attack

☐Stroke

☐Heart bypass

☐Vascular disease

☐High blood pressure

☐High cholesterol

☐Heart arrhythmia

☐Emphysema (COPD)

☐Tuberculosis

☐Glaucoma

☐ADD/ADHD

☐Depression/anxiety

☐Manic depression

☐Schizophrenia

☐Kidney disease

☐Seizures

☐Irritable Bowel Type Symptoms

☐Psychological/psychiatric illness___________________

☐Restless leg

☐Sleep apnea

☐Prostate enlargement

☐Arthritis

☐Rheumatoid arthritis

☐Fibromyalgia

☐Lupus or autoimmune disease

☐Urinary Symptoms

☐Chronic fatigue

☐Adrenal fatigue

☐Multiple sclerosis

☐Diabetes type 1

☐Diabetes type 2

☐Hypoglycemia

☐Insulin resistance

☐Thyroid disease Hypo___________ Hyper___________

☐Addisons disease or cushings disease

☐Liver disease

☐Glaucoma

☐ GI Upset/GERD

☐Other ____

Surgical History: Please list all surgeries and approximate dates.

____

____

____

____

Social History: Please mark any of the following that may apply.

☐I have completed my family

☐I am married

☐I have a partner

☐I am in a committed relationship

☐I am sexually active

☐I want to be sexually active

Habits: Please mark any of the following that may apply.

Smoking:

☐Never Smoked

☐I smoke cigarettes: packs per day:_______

☐I smoked previously. Quit Date: ________

☐ I use vapor cigarettes

Drinking:

☐ I don't drink , but not due to problem with alcohol

☐I drink more than 12 drinks per week

☐ I drink less than 12 drinks per week

☐ I am a recovering alcoholic

Caffeine:

☐I drink caffeinated beverages. _________servings/day. Type: _____________________

Other Drugs:

☐I use or have used marijuana in the last year

☐I use cocaine or Heroin or have a history with the use of them.

☐ I use other drugs: ____

Exercise History: Please mark any of the following that may apply

☐I don't exercise ☐Normal daily activity is what I consider exercise

☐I have a very physical job so I don't exercise ☐I am a long distance runner

☐I exercise every day for ______ minutes ☐I lift weights ______ times a week

☐I exercise more than 3 times/week > 50min. ☐Other:____

Dieting: Please mark any of the following that may apply.

Do you overeat? ☐Yes ☐No, How is your appetite?____

Do you ever have any reactions to food? ☐Yes ☐No ____

Do you crave sweets? ☐Yes ☐No, Or any other food cravings?_____________________________________

☐I eat anything I want ☐I limit my carbohydrates

☐I don't eat much but gain weight anyways ☐I eat a low fat diet

☐I have gained weight in my belly since 40 ☐Atkins

☐I eat a balanced diet, 3 times a day ☐Vegan/vegetarian

☐I eat 6 small meals per day ☐Special diet/restrictions ___________________________

☐Other____

Preventive Medical Care: Please list the date that corresponds with the exam.

☐Physical exam Date _________________________ ☐Labs ______________________________________

☐Prostate exam Date ________________________ ☐PSA test Date ______________________________

☐Bone Density Date _________________________ ☐Colonoscopy Date __________________________

Polyps? ☐Yes ☐No

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Family History (mother/father/sister/brother): Please mark any of the following that may apply.

☐Heart disease
☐Alzheimer's/dementia of any type
☐Colon cancer
☐Prostate cancer
☐Breast cancer
☐Blood clots/Bleeding Disorders
☐Uterine cancer
☐Rheumatoid arthritis/Lupus
☐Other Cancer: ________________________
☐ Other Autoimmune Disease
☐Stroke
☐Thyroid disease- high or low
☐Arrhythmia
☐Osteoporosis
☐Diabetes
☐Hemochromatosis
☐Any other pertinent family history ____

Anti-Aging/Hormone Consultation Patients: Please mark any of the following that may apply.

Sexual History (present): Please mark any of the following that may apply.

☐I've had a new sex partner in the last 3 yrs
☐My sex life is good
☐I have the ability to ejaculate
☐I could ejaculate before I was 40, but not now
☐I had sexual fantasies in the past
☐I still have sexual fantasies
☐My sex life has gotten worse after 40
☐My sex life is better than before I was 40

Hormone Replacements I have used in the past: Please mark any of the following that may apply.

☐Pellets
☐Patches
☐Gel/creams applied on the skin
☐Injectables
☐Other____

I UNDERSTAND THAT DR. OHMS DOES NOT DO PAP/PELVIC EXAMS OR PROSTATE EXAMS ON ANY PATIENTS. PLEASE DO THESE REGULAR TESTS WITH YOUR GYNECOLOGIST, UROLOGIST AND/OR PRIMARY CARE (IF DR. OHMS IS NOT YOUR PRIMARY CARE DOCTOR). I AGREE TO HAVE THESE AS WELL AS MAMMOGRAMS, CLINICAL BREAST EXAMS, AND ANY OTHER ROUTINE HEALTH MAINTENANCE/PREVENTIVE TESTING INDICATED IN MY SPECIFIC CASE DONE PER CLINICAL GUIDELINES. I UNDERSTAND THAT DR. OHMS WILL NOT BE ABLE TO CONTINUE CERTAIN TREATMENTS (ESPECIALLY HORMONE REPLACEMENT), IF I AM NOT UP TO DATE WITH MY ROUTINE PREVENTIVE CARE TESTS.

NAME (PRINT): ____

SIGNATURE: ____ DATE: _______________________

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY MEDICAL CARE AND I, THEREFORE CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM DR. OHMS OF ANY CHANGES OR UPDATES.

NAME (PRINT): ____

SIGNATURE: ____ DATE: _______________________

I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SUBMIT CLAIMS TO INSURANCE FOR POSSIBLE REIMBURSEMENT. I UNDERSTAND THAT BALANCED REJUVENATION HAS NO CONTRACTS WITH MEDICARE AND/OR ANY OTHER INSURANCE COMPANY. THEREFORE, BALANCED REJUVENATION IS NOT OBLIGATED TO PRE-CERTIFY TREATMENT, PROCESS PRIOR AUTHORIZATIONS OR ANSWER LETTERS OF APPEAL.

NAME (PRINT): ____

SIGNATURE: ____ DATE: _______________________

HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? _____Yes _____No Ok to leave message? _____Yes _____No

May we contact you at work? _____Yes _____No Ok to leave message? _____Yes _____No

May we contact you via cell? _____Yes _____No Ok to leave message? _____Yes _____No

Is it ok to leave a message that includes:

Practice name and phone number only? _____Yes _____No

Detailed or specific message? _____Yes _____No

Would you like to authorize someone else to schedule, confirm, or change appointments? _____Yes _____No

If so, please provide:

Name ____ Phone __________________________________

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name ____

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter?
_____Yes _____No

HOW DID YOU HEAR ABOUT US?

___ Friend or Family Member (Name) ____

___ Website: ___ *BalancedRejuvenationMed.com*

___ Internet Search (Google / Yahoo / Other) ____

___ Newspaper/Newsletter or Mailer ____

___ An Article or Advertisement in ____

___ Other ____

Deanna Ohms, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on her website www.balancedrejuvenationmed.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

Name:_______________________________ Signature:_________ ________________________ Date:______________