PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

# MALE INTAKE QUESTIONNAIRE

## GENERAL INFORMATION

NAME _____ AGE _____ TODAY'S DATE _____

DATE OF BIRTH _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ PHONE (HOME) _____ (CELL) _____

HEIGHT _____ WEIGHT _____ SOCIAL SECURITY# _____ (FOR SCHEDULED RX)

WHO IS YOUR PRIMARY CARE PHYSICIAN AND WHO DID YOU LAST SEE FOR CARE?

_____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE (HOME) _____ (CELL) _____

## CURRENT HEALTH CONCERNS

PLEASE RANK CURRENT AND ONGOING HEALTH CONCERNS IN ORDER OF PRIORITY.

| DESCRIBE PROBLEM / SEVERITY | MILD | MODERATE | SEVERE | PRIOR TREATMENT/APPROACH / SUCCESS | EXCELLENT | GOOD | FAIR |
|---|---|---|---|---|---|---|---|
| *EXAMPLE: LOW LIBIDO* | *X* | | | *VIAGRA* | | *X* | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10. | | | | | | | |

## HEALTH GOALS

WHAT DO YOU HOPE TO ACHIEVE IN YOUR VISIT WITH US? _____

_____

_____

_____

## ALLERGIES

| NAME OF MEDICATION/SUPPLEMENT/FOOD: | REACTION: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

# LIFESTYLE REVIEW

## SLEEP

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT ON AVERAGE? _____

DO YOU HAVE PROBLEMS FALLING ASLEEP? Y/N

STAYING ASLEEP? Y/N

DO YOU SNORE? Y/N

DO YOU FEEL RESTED UPON AWAKENING? Y/N

DO YOU USE SLEEPING AIDS? Y/N

IF YES, EXPLAIN: _____

DO YOU HAVE SLEEP APNEA? Y/N

## EXERCISE

**CURRENT EXERCISE PROGRAM:**

| ACTIVITY | TYPE | # OF TIMES PER WEEK | TIME/DURATION (MINUTES) |
|---|---|---|---|
| CARDIO/AEROBIC | | | |
| STRENGTH/RESISTANCE | | | |
| FLEXIBILITY/STRETCHING | | | |
| BALANCE | | | |
| SPORTS/LEISURE (I.E. GOLF) | | | |

## NUTRITION

DO YOU CURRENTLY FOLLOW ANY OF THE FOLLOWING SPECIAL DIETS OR NUTRITIONAL PROGRAMS? (CHECK ALL THAT APPLY)

- ○ VEGETARIAN ○ VEGAN ○ ELIMINATION
- ○ LOW FAT ○ LOW SODIUM ○ NO DAIRY
- ○ LOW CARB ○ HIGH PROTEIN ○ GLUTEN FREE

OTHER: _____

DO YOU HAVE FOOD SENSITIVITIES? Y/N

IF YES, LIST FOOD/SYMPTOMS _____

DO YOU DRINK CAFFEINATED BEVERAGES? Y/N

IF YES, CIRCLE AMOUNT:

COFFEE (CUPS PER DAY) 1 2-4 >4 TEA (CUPS PER DAY) 1 2-4 >4

CAFFEINATED SODAS - REGULAR OR DIET (CANS PER DAY) 1 2-4 >4

## smoking

DO YOU SMOKE CURRENTLY? Y/N PACKS PER DAY: _____ NUMBER OF YEARS: _____

WHAT TYPE? CIGARETTES SMOKELESS PIPE CIGAR E-CIG

IF YOU SMOKED PREVIOUSLY: PACKS PER DAY: _____ NUMBER OF YEARS: _____

## alcohol

HOW MANY ALCOHOLIC BEVERAGES DO YOU DRINK IN A WEEK?

*(1 DRINK = 5 OUNCES WINE, 12 OUNCES BEER, 1.5 OUNCES SPIRITS)*

1–3 4–6 7–10 >10 NONE

PREVIOUS ALCOHOL INTAKE? YES (MILD MODERATE HIGH) NO

HAVE YOU EVER HAD A PROBLEM WITH ALCOHOL? Y/N

### STRESS

DO YOU FEEL YOU HAVE AN EXCESSIVE AMOUNT OF STRESS IN YOUR LIFE? Y/N

DO YOU FEEL YOU CAN EASILY HANDLE THE STRESS IN YOUR LIFE? Y/N

### RELATIONSHIPS

**MARITAL STATUS:**

SINGLE MARRIED DIVORCED LONG-TERM PARTNER WIDOW/ER

CURRENT OCCUPATION: _____

## HISTORY

**MEN'S HISTORY** (CHECK BULLET IF APPLICABLE)

- ○ TESTICULAR MASS
- ○ PROSTATE ENLARGEMENT
- ○ PROSTATE INFECTION
- ○ PREMATURE EJACULATION
- ○ DIFFICULTY MAINTAINING AN ERECTION
- ○ URINARY URGENCY/HESITANCY/CHANGE IN STREAM
- ○ NOCTURIA (URINATION AT NIGHT)
  - ➢ # OF TIMES PER NIGHT _____
- ○ TESTICULAR PAIN
- ○ CHANGE IN SEX DRIVE
- ○ IMPOTENCE
- ○ DIFFICULTY OBTAINING AN ERECTION
- ○ LOSS OF CONTROL OF URINE
- ○ VASECTOMY
- ○ SEXUALLY TRANSMITTED DISEASES
  - ➢ DESCRIBE_ _____

## FAMILY HISTORY:

**CHECK FAMILY MEMBERS THAT HAVE/HAD ANY OF THE FOLLOWING:**

| | Mother | Father | Brother (s) | Sister (s) | Child | Child | Child | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age (if still alive)* | | | | | | | | | | | | | |
| *Age at death (if deceased)* | | | | | | | | | | | | | |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures/epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psychiatric disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ADHD | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dementia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Substance abuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Genetic disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## MEDICAL HISTORY: ILLNESSES/CONDITIONS

**YES = A CONDITION YOU CURRENTLY HAVE; PAST = A CONDITION YOU'VE HAD IN THE PAST.**

| GASTROINTESTINAL | YES | PAST |
|---|---|---|
| IRRITABLE BOWEL SYNDROME | ☐ | ☐ |
| GERD (REFLUX) | ☐ | ☐ |
| CROHN'S DISEASE/ULCERATIVE COLITIS | ☐ | ☐ |
| PEPTIC ULCER DISEASE | ☐ | ☐ |
| CELIAC DISEASE | ☐ | ☐ |
| GALLSTONES | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **RESPIRATORY** | | |
| BRONCHITIS | ☐ | ☐ |
| ASTHMA | ☐ | ☐ |
| EMPHYSEMA | ☐ | ☐ |
| PNEUMONIA | ☐ | ☐ |
| SINUSITIS | ☐ | ☐ |
| SLEEP APNEA | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **URINARY/GENITAL** | | |
| KIDNEY STONES | ☐ | ☐ |
| GOUT | ☐ | ☐ |
| INTERSTITIAL CYSTITIS | ☐ | ☐ |
| FREQUENT YEAST INFECTIONS | ☐ | ☐ |
| FREQUENT URINARY TRACT INFECTIONS | ☐ | ☐ |
| SEXUAL DYSFUNCTION | ☐ | ☐ |
| SEXUALLY TRANSMITTED DISEASES | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **ENDOCRINE/METABOLIC** | | |
| DIABETES | ☐ | ☐ |
| HYPOTHYROIDISM (LOW THYROID) | ☐ | ☐ |
| HYPERTHYROIDISM (OVERACTIVE THYROID) | ☐ | ☐ |
| INFERTILITY | ☐ | ☐ |
| METABOLIC SYNDROME/INSULIN RESISTANCE | ☐ | ☐ |
| EATING DISORDER | ☐ | ☐ |
| HYPOGLYCEMIA | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **INFLAMMATORY/IMMUNE** | | |
| RHEUMATOID ARTHRITIS | ☐ | ☐ |
| CHRONIC FATIGUE SYNDROME | ☐ | ☐ |
| FOOD ALLERGIES | ☐ | ☐ |
| ENVIRONMENTAL ALLERGIES | ☐ | ☐ |
| MULTIPLE CHEMICAL SENSITIVITIES | ☐ | ☐ |
| AUTOIMMUNE DISEASE | ☐ | ☐ |
| IMMUNE DEFICIENCY | ☐ | ☐ |
| MONONUCLEOSIS | ☐ | ☐ |
| HEPATITIS | ☐ | ☐ |
| OTHER: | ☐ | ☐ |

| MUSCULOSKELETAL | YES | PAST |
|---|---|---|
| FIBROMYALGIA | ☐ | ☐ |
| OSTEOARTHRITIS | ☐ | ☐ |
| CHRONIC PAIN | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **SKIN** | | |
| ECEMA | ☐ | ☐ |
| PSORIASIS | ☐ | ☐ |
| ACNE | ☐ | ☐ |
| SKIN CANCER | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **CARDIOVASCULAR** | | |
| ANGINA | ☐ | ☐ |
| HEART ATTACK | ☐ | ☐ |
| HEART FAILURE | ☐ | ☐ |
| HYPERTENSION (HIGH BLOOD PRESSURE) | ☐ | ☐ |
| STROKE | ☐ | ☐ |
| HIGH BLOOD FATS (CHOLESTEROL, TRIGLYCERIDES) | ☐ | ☐ |
| RHEUMATIC FEVER | ☐ | ☐ |
| ARRYTHMIA (IRREGULAR HEART RATE) | ☐ | ☐ |
| MURMUR | ☐ | ☐ |
| MITRAL VALVE PROLAPSE | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **NEUROLOGIC/EMOTIONAL** | | |
| EPILEPSY/SEIURES | ☐ | ☐ |
| ADD/ADHD | ☐ | ☐ |
| HEADACHES | ☐ | ☐ |
| MIGRAINES | ☐ | ☐ |
| DEPRESSION | ☐ | ☐ |
| ANXIETY | ☐ | ☐ |
| AUTISM | ☐ | ☐ |
| MULTIPLE SCLEROSIS | ☐ | ☐ |
| PARKINSON'S DISEASE | ☐ | ☐ |
| DEMENTIA | ☐ | ☐ |
| OTHER: | ☐ | ☐ |
| **CANCER** | | |
| UNG | ☐ | ☐ |
| BREAST | ☐ | ☐ |
| COLON | ☐ | ☐ |
| PROSTATE | ☐ | ☐ |
| SKIN | ☐ | ☐ |
| OTHER: | ☐ | ☐ |

## MEDICAL HISTORY *(cont.)* DIAGNOSTIC STUDIES

| | Date | Comments |
|---|---|---|
| Bone density | | |
| CT scan | | |
| Colonoscopy | | |
| Cardiac stress test | | |
| EG | | |
| MRI | | |
| Upper endoscopy | | |
| Upper GI series | | |
| Chest Xray | | |
| Other Xrays | | |
| Barium enema | | |
| Other: | | |
| **Inuries** | | |
| Broken bone(s) | | |
| Back inury | | |
| Neck inury | | |
| Head inury | | |
| Other: | | |
| **Surgeries** | | |
| Appendectomy | | |
| Dental | | |
| Gallbladder | | |
| Hernia | | |
| Tonsillectomy | | |
| Joint replacement | | |
| Heart surgery | | |
| Other: | | |
| **Hospitaliations** | **Date** | **Reason** |
| | | |
| | | |
| | | |
| | | |
| | | |

## MEDICATIONS/SUPPLEMENTS

### CURRENT MEDICATIONS (INCLUDE PRESCRIPTION AND OVER-THE-COUNTER)

| MEDICATION | DOSAGE | START DATE (MO/YR) | REASON FOR USE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS ETC.)

| NAME AND BRAND | DOSAGE | START DATE (MO/YR) | REASON FOR USE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LIST ANY MEDICATIONS AND SUPPLEMENTS YOU HAVE TAKEN IN THE PAST AND EXPLAIN WHY YOU STOPPED USING THEM: _____

_____

_____

_____

_____

_____

HAVE MEDICATIONS OR SUPPLEMENTS EVER CAUSED UNUSUAL SIDE EFFECTS OR PROBLEMS? Y/N

IF YES, DESCRIBE: _____

HAVE YOU USED ANY OF THESE REGULARLY OR FOR A LONG TIME:

NSAIDs (ADVIL/MOTRIN/IBUPROFEN/ASPIRIN)? Y/N

TYLENOL (ACETAMINOPHEN)? Y/N

ACID-BLOCKING DRUGS (ZANTAC/PRILOSEC/NEXIUM)? Y/N

## Financial Policy and Assignment of Benefits

Precision Regenerative and Functional Medicine is dedicated to providing the best possible care and service to you. We regard your understanding of all your financial responsibilities as an essential element of your treatment.

* We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept an assignment of benefits. We will bill those plans and will only require you to pay the authorized copayment, coinsurance and/or deductible at the time of service. **The office policy is to collect this copayment, coinsurance and/or deductible when you arrive for your appointment.** This amount is an estimate and is based on the most recent insurance verification obtained by our office staff.

* If your insurance policy requires a referral for Precision Regenerative and Functional Medicine, please understand we will request this referral from your referring practitioner prior to your appointment, but it is ultimately your responsibility to obtain this referral. If your services are denied because the referral was not received, you will be responsible for the full charged amount.

* **Private pay patients are required to pay in full at the time of service.** A quote will be provided for any and all procedures prior to your appointment.

* We accept VISA, Mastercard, and Discover. Please be advised that there is a $20 service charge on all returned checks.

* Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assign the benefits to our doctor. If your insurance company does not pay our office within 90 days, you will be responsible for payment. If we later receive a check from your insurer, we will refund any overpayment.

* All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

* If you have a medical procedure performed by our physician at a location other than our office you and/or your insurance company will receive two bills, one from our physician for his professional services and one from the facility where the procedure was performed.

* For all services rendered to minor patients, the parent and/or legal guardian will be responsible for payment.

* If you receive a statement from Precision Regenerative and Functional Medicine the balance needs to be paid in full within 30 days of receipt unless prior arrangements have been made. Any remaining balances due after 90 days will be considered delinquent and will be turned over to an outside collection agency. Future appointments will not be scheduled until balances have been paid in full or a written payment plan has been agreed to by our office. Please be sure to update any contact changes with our office staff so you can be reached regarding your balance.

* In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. Please see the attached cancelation no show polices and fees.

* I hereby assign all medical and surgical benefits, to include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and other health/ medical plan, to issue payment check(s) directly to **Precision Regenerative and Functional Medicine** for medical services rendered to myself and/ or my dependents regardless of my insurance. In the event that the insurance payment is sent directly to me, I realize that I will be billed personally until the balance is paid.

**I have read and understand the financial policy and assignment of benefits of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time-to-time.**

_____ _____

patient/responsible party signature date

# *AUTOMATIC BILLING AUTHORIZATION FORM*

Company Name: **Precision Regenerative and Functional Medicine** ID Number: _____

## FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

| **Primary Card Account** | **Secondary Card Account** |
|---|---|
| _____ Name on credit card (exactly as printed) | _____ Name on credit card (exactly as printed) |
| _____ Billing Address for credit card (Street, Apt. #) | _____ Billing Address for credit card (Street, Apt. #) |
| _____ City, State Zip | _____ City, State Zip |
| _____ Credit card number Expiration Date | _____ Credit card number Expiration Date |
| _____ Signature Today's Date | _____ Signature Today's Date |

☑ Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.
☑ This authorization is valid until I provide you with written cancellation.

- I authorize the charge of all copays, co-insurance or deductible amounts due for all in office and telemedicine visits.
- I authorize the charge of all No-Show or Missed appointment fees. I have reviewed and signed the Cancelation and No-Show Polices and Fee document.
- I authorize the charge for all clinic lab fees for labs drawn at PRFM.
- I authorize the charge for any peptides, HRT products that are ordered and paid for by PRFM and shipped directly to my home.
- I authorize the charge for any unpaid balances over 30 days old.

PATIENT SIGNATURE: _____ DATE: _____

## CANCELLATION AND NO SHOW POLICIES AND FEES

This is a reminder of our policy regarding missed appointments. When one patient misses their appointment and does not let us know, or when one patient cancels their appointment late (less than 24 hours prior to the appointment), it not only affects our staff, but also other patients.

As you know, our patients are in pain. They like to be seen and treated as soon as possible. We do our best to see and treat everybody as soon as we can, but also allow enough time on our schedule for every patient to be heard and examined, and for questions to be answered. We are respectful of our patients' time, and we ask our patients to be respectful of our time.

When somebody does not call to cancel their appointment and simply just does not show up, or calls and cancels their appointment at the last minute, we cannot schedule another patient on such short notice. We lose time that day and somebody else continues to wait to see us, while suffering in pain.

Charging for missed appointments is not something we like to do. It can be avoided with a minimum of courtesy and good communication. Please help us continue to treat you and everybody else at the standards you deserve.

### FOLLOW UP APPOINTMENTS

no-show or missed without 24 hours notice will be charged **$50.00**

canceled with less than 24 hours notice will be charged **$25.00**

if you arrive more than 15 minutes late for a follow up appointment, your appointment may be rescheduled and you will be charged **$25.00**
**(this is at the providers discretions)**

### PROCEDURE APPOINTMENTS

no-show or missed without 24 hours notice will be charged **$150.00**

canceled with less than 24 hours notice will be charged **$50.00**

### NEW PATIENT APPOINTMENTS

no-show or missed without 24 hours notice will be charged **$50.00**

canceled with less than 24 hours notice will be charged **$25.00**

**FEES NEED TO BE PAID IN FULL BEFORE APPOINTMENTS WILL BE RESCHEDULED**

PATIENT SIGNATURE: _____ DATE: _____

# Authorization for Release and Disclosure of Protected Health Information

In accordance with state law and regulatory agency requirement, the health record is the property of Precision Regenerative and Functional Medicine (PRFM). I hereby authorize the PRFM Medical Records custodian to release information from the medical records of:

patient name: _____ dob: _____ ssn: _____

address: _____ city/state/zip: _____

telephone: _____ alternate contact number: _____

**Information may be released to:**

Precision Regenerative and Functional Medicine
1101 S. Capital of Texas Hwy
building F, ste. 101
Austin, Texas 78746
(512) 892-0490

**Facility or Physician:**

name:_____
address:_____
city/state/zip:_____
phone:_____

**Please release the following information:**

____problem list ____xray reports ____mental health ____outside reports
____progress notes ____xray Films ____drugs/alcohol ____immunizations
____EKG reports ____lab report ____HIV/AIDS test ____medication list
____history and physical exam finding ____other reports _____

**This information is necessary for the following:**

____continued patient care ____personal use ____attorney/legal ____insurance

____other (specify)_____

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information that has already been release in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the follow days, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 892-0490.

_____ _____
signature of patient or legal representative date

_____ _____
relationship to patient date

## ACKNOWLEDGMENT OF RECEIPT AND PRIVACY NOTICE

I, _____, understand that as part of my health care, Precision Regenerative and Functional Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care. I understand that this information serves as:

* A basis for planning my treatment;
* A means to facilitate communication among the many healthcare professionals who contribute to my care;
* A source of information for applying my diagnosis and surgical information to my bill;
* A means by which a third-party payer can verify that services billed were actually provided;
* A tool for healthcare operations of Precision Regenerative and Functional Medicine such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of Precision Regenerative and Functional Medicine treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above. I understand I have the right to review a **NOTICE OF PRIVACY PRACTICES** that provides a more complete description of how Precision Regenerative and Functional Medicine may use and disclose my protected healthcare information. I further understand that Precision Regenerative and Functional Medicine reserves the right to change its **NOTICE OF PRIVACY PRACTICES**. Should Precision Regenerative and Functional Medicine change its **NOTICE OF PRIVACY PRACTICES**, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.
I agree that Precision Regenerative and Functional Medicine may do the following unless I specifically give direction prohibiting such activity:

* Send visit reminders and test results to the address I have provided.
* Send routine correspondence, such as billing statements, to the address I have provided.
* Leave messages on answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the practice for medical or billing matters.
* Speak to or leave message with the family members/friends listed below:

NAME: _____ RELATIONSHIP TO PATIENT: _____ CONTACT NUMBER: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____ CONTACT NUMBER: _____

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

## INFORMED CONSENT FOR ANABOLIC HORMONE THERAPY

It is important that you understand the potential risks of starting anabolic hormone therapy, along with the many benefits we have already discussed. There are alternatives to anabolic hormone therapy, such as the lifestyle changes and nutraceutical supplementation, that have been discussed with you.

*THE FOLLOWING IS A LIST OF THE POTENTIAL SIDE EFFECTS OF ANABOLIC HORMONE THERAPY:*

**NEUROPSYCHOLOGICAL**

- Some patients can become more aggressive or have other subtle mental health changes while on anabolic hormone therapy. **If you notice negative changes in mood or overall mental health, contact the office to get a follow up appointment.**
    - initial _____

**MUSCULOSKELETAL**

- It is likely that anabolic hormone therapy will cause an increase in lean muscle tissue, which will manifest in a heavier weight. At the same time, weight loss may also occur due to the reduction in fat mass.
- Although rare, an additional potential consequence of increasing estrogen levels is swelling breast tissue, or gynecomastia.
    - initial _____

**GENITOURINARY**

- Atrophy of the testicles, decreased sperm count, changes in sperm morphology, and infertility will most likely occur.
    - **If fertility is desired, this cannot be understated.**
- If you have prostate cancer that has not yet been diagnosed, it can grow with the use of anabolic hormones. Your PSA levels will need to be monitored at least every 6 months. A baseline MRI may be ordered to evaluate the prostate if desired.
- It is possible that anabolic hormone therapy can increase prostate size, leading to a condition called benign prostatic hypertrophy (BPH), which can make it hard to urinate. If you have issues with urination or getting up multiple times at night to go to the bathroom, make sure to discuss them with your provider.
- Strict, monotherapy regimens of the synthetic options, such as nandrolone decanoate, may result in a loss of libido.
    - initial _____

**HEMATOLOGIC**

- Bone marrow can be stimulated with anabolic hormone therapy, so blood cell counts must be monitored.
- Anabolic hormones can make the blood "thicker," which can increase the risk of blood clots. At the same time, anabolic hormone therapy typically increases the anti-coagulation system in the blood, which has a protective effect on the vasculature.
    - It is important to monitor blood pressure, as the increase in hematocrit, i.e the thickness of the blood, may increase the workload of the heart and the pressures it exerts. **If you notice that your blood pressure is consistently higher than it was at baseline, contact the office to get a follow up appointment.**
        - initial _____

**HEPATIC**

- Orally available anabolic hormones like oxandrolone (Anavar) can irritate the liver in some people, so your liver function will be tested routinely if you are prescribed such a formulation.
    - initial _____

**DERMATOLOGIC**

- Because testosterone can metabolize into dihydrotestosterone (DHT), some forms of anabolic hormone therapy are associated with the induction or worsening of alopecia, or hair loss. If this is a concern, discuss it with your provider prior to signing this form and beginning therapy, if it has not been addressed already.
    - An additional side effect of increasing DHT in the body is acne, particularly on the back, shoulders, and jawline.
        - initial _____

**CARDIOVASCULAR**

- Some studies hint at increased risk of heart attack and stroke in men on anabolic hormone replacement, especially older men and men who already have cardiovascular diseases. However, there is also a copious amount of data that suggests the opposite. Lipoprotein, inflammatory, and endothelial parameters will be measured at least every 6 months to assess for changes.
    - initial _____

**ONCOLOGIC**

- Because testosterone can metabolize into estrogen, males who have breast cancer (or who are at high risk for breast cancer) should not use testosterone except under special circumstances. Non-aromatizing anabolic hormone therapy may still be an option.
    - initial _____

continued on next page.

***PLEASE READ THE FOLLOWING AND SIGN:***

I have discussed the reason for taking anabolic hormones with my provider and understand why he is prescribing them and the risks associated with taking hormones, including but not limited to the possibility of an increased risk of breast or prostate cancer, blood clotting, stroke, or heart attack.

I understand that there are **BLACK BOX WARNINGS** for the following medications:

1. *OXANDROLONE*
    a. **ARTERIOSCLEROSIS; CARDIAC DISEASE; CORONARY ARTERY DISEASE; HEART FAILURE; HYPERCHOLESTEROLEMIA; MYOCARDIAL INFARCTION; PERIPHERAL EDEMA.**
2. *TESTOSTERONE/ANABOLIC STEROID CREAMS*
    A. **VIRILIZATION OF CHILDREN DUE TO SECONDARY EXPOSURE. CHILDREN SHOULD AVOID CONTACT WITH UNWASHED OR UNCLOTHED APPLICATION SITES.**

I understand that my provider will do everything they know to do to decrease and minimize the risks of HRT but that there are no guarantees that these measures will be effective at preventing the negative side effects mentioned above or others that we do not yet know about.

I understand the diagnostic tests that are available that would help quantify my risk for potential adverse effects and that getting them performed or not is my choice.

I also acknowledge that this may be off label use and may not considered the standard of care for my clinical presentation.

I accept the risks and unknowns of taking hormone therapy and wish proceed with therapy.

**IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT STARTING THERAPY, DO NOT SIGN THIS FORM UNTIL YOU HAVE DISCUSSED THEM WITH YOUR PROVIDER.*

_____ _____

PATIENT NAME DATE

_____ _____

SIGNATURE DATE