Ph: (757) 410-5462

Patient Information Form For Men

NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE: (_____)_____

CELLULAR TELEPHONE: (_____)_____

WORK TELEPHONE: (_____)_____

EMAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____PHONE:_____

REASON FOR VISIT: _____

How did you hear about us (please check):
Wife _____ Internet_____ Friend_____ Other _____

Synergy Integrative Medical Center
Patient Intake form for Men **MR#** _____

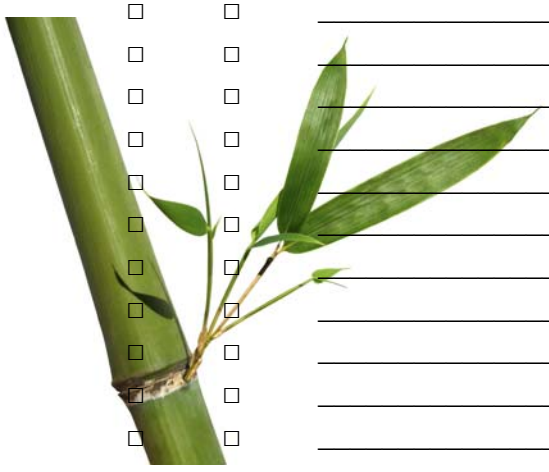
Name _____ **age**_____ **Date** _____

Primary Care Doctor _____ **Referred by** _____

Concern(s): Please rank by priority Example: Headaches	**Onset** 2 years ago	**Frequency** 2x/wk	**Severity** mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____
_____
_____
_____

Illnesses – yours & your family's	**Self**	**Family**	**List family members who have had these illnesses**
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Lung disease	☐	☐	_____
Hepatitis	☐	☐	_____
Digestive diseases	☐	☐	_____
Seizures	☐	☐	_____
Thyroid disease	☐	☐	_____
Mental disorders	☐	☐	_____
Osteoporosis	☐	☐	_____
Other _____	☐	☐	_____
Other _____	☐	☐	_____



Have you fathered any pregnancies? ____ yes ___ no

Is infertility a concern for you? ____ yes ___no

Operations **Injuries**

What	When	What	When

Please list all medications, vitamins, herbs and supplements which you now take regularly, prescribed or over-the-counter.

Name & dosage	**Reason**	**When started**	**Who recommended**

Allergies or intolerances to medicines:

Medication	Reaction/intolerance symptoms

Occupation, or previous occupation if retired: _____

What interests/hobbies do you have? _____

_____

_____

With whom do you live?

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you do? _____

_____

What are the major stressors in your life? _____

_____

_____

What do you do to relax? (or what would you like to do?) _____

_____

_____

Religious affiliation _____

What prior experiences have you had with complementary and alternative medicine? _____

_____

_____

Tobacco use: □ never used □smoked from age ___ to ___ . ____ packs per day.

Alcohol use: □ never used □estimated ____ drinks per week.

□ history of alcohol abuse

Recreational drugs: □ never used □ type _____

Health screening:

Have you had?	No	Yes	Date of most recent	Who ordered/performed
PSA				
Colonoscopy				
Prostate exam				
Bone density test				
Cholesterol test				

Review of symptoms:

Sleep _____ hrs/night sleep problems _____do you have sleep apnea? y n

Hair problems _____

Erection problems/impotence/ED y n

Do you have erections while sleeping or in the morning? y n

Other sexual problems (list) _____

Intolerance to heat or cold (circle if applicable)

Fatigue y n

Dry skin y n

Frequent or severe headaches y n

Weight loss y n Weight gain y n

Swelling y n describe _____

Palpitations y n

Breast enlargement y n

Frequent crying or depression y n

Weakness y n

Joint pain y n

Muscle problems y n

Stomach/bowel problems y n describe _____

Urinary problems y n describe _____

Nutrition Evaluation

Dietary intake. Please list **all** food and drinks you have consumed in the past 24 hours. Be honest – don't write what you think we want to hear. You're only hurting yourself.

Food or drink **how prepared (baked, fried, etc)** **amount (cups, tbsp, ounces, etc)**

Any food you avoid, and why _____

Was this a typical day? If not, why not? _____

ED Questionnaire for Men

Each question has several possible responses. Circle the number of the responses that best describes your own situation. Please be sure that you select one response for each question.

OVER THE PAST 6 MONTHS:

How do you rate your confidence that you could get and keep an erection?		**Very Low**	**Low**	**Moderate**	**High**	**Very High**
		1	**2**	**3**	**4**	**5**
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	**No sexual activity**	**Almost Never or Never**	**A Few Times (much less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	**Do not attempt intercourse**	**Almost Never or Never**	**A Few Times (must less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**Do not attempt intercourse**	**Extremely Difficult**	**Very Difficult**	**Difficult**	**Slightly Difficult**	**Not Difficult**
	0	**1**	**2**	**3**	**4**	**5**
When you attempted sexual intercourse, how often was it satisfactory for you?	**Do no attempt intercourse**	**Almost Never or Never**	**A Few Times (much less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**

Add the numbers: **TOTAL** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1 – 7 Severe ED
8 – 11 Moderate ED
12 – 16 Mild to Moderate ED
17 – 21 Mild ED

Consent For Hormone Supplementation Therapy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the physicians of Synergy Medical Center. I acknowledge that there are no guarantees or assurances made with respect to the benefit of Hormones Supplementation Therapy prescribed for me.

I understand that I will be in charge of administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests must and will be performed to establish my baseline hormone level. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to communicate with the physicians at Synergy Medical Center , any adverse reaction or problems that might be related to my Hormone Therapy. I understand that with Hormone Supplementation, there are possible risks and complications, if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that Hormone Supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the physicians of Synergy Medical Center is for Hormone Replacement Therapy Supplementation only, and that I agree I am and will be under the care of another physician for all other medical conditions. Synergy physicians are available during daytime working hours only.

I have been informed that insurance companies and Medicare do not pay for Hormone Replacement Therapy: I therefore agree to pay Synergy Medical Center and any pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understood all of the above consent conditions. I have had other information given to me about Hormone Supplementation Therapy, so that I fully understand what I am signing and hereby request and consent to treatment using Hormone Supplementation Therapy.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date