



An Integrative Medical Center

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 _____

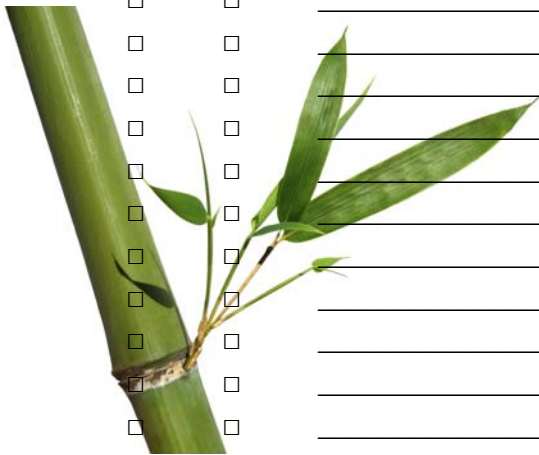
Concern(s): Please rank by priority Example: Headaches	Onset 2 years ago	Frequency 2x/wk	Severity mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____

Illnesses – yours & your family’s

List family members who have had these illnesses

	Self	Family	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestive diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____



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 _____

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 (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 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 not 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

Medical Appointment Cancellation Policy

Dear Patient,

Synergy Integrative Medicine strives to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, Synergy uses an appointment system that sets aside time for a patient dependent on that patient's need. When you do not show up for your appointment or notify us of your inability to keep your appointment at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to have time available for all patients, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment and does not contact us with at least a 24 hour notice, we consider this to be a missed appointment, "No Show, No Call", and the following fees will be accessed:

BHRT follow up appointments (30 minutes)	\$100.00
BHRT 1 year follow up appointments (1 hour)	\$175.00
Wellness follow up appointments (30 minutes)	\$100.00
Wellness 1 year follow up appointments (1 hour)	\$150.00

As a courtesy, we do make reminder calls for appointments. If you do not receive your message or we have incorrect information, the cancellation policy will still be in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

Printed Name of the Patient

Relationship to Patient (if patient is a minor)

Signature of Patient or Responsible Party

Date