PATIENT INFORMATION FORM

NAME: _____ DATE: _____
First Middle Last

ADDRESS:_____CITY:_____STATE:_____

ZIP: _____ CELL #: _____ HOME #: _____

SOC SECURITY #: _____ DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

EMAIL ADDRESS: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED

IF COLLEGE STUDENT: FT / PT CITY: _____ STATE: _____

NAME OF SCHOOL: _____

PATIENTS EMPLOYER: _____ WORK #: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE OR PARENTS NAME: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

DRIVER'S LICENSE #: _____ STATE: _____

ADDRESS: _____

CONTACT #: _____ ( ) CELL ( ) HOME

PATIENT SIGNATURE: _____ DATE: _____

Health History Questionnaire

Patient Name: _____ DOB: _____ Date: _____
Occupation: _____
Primary Care Doctor (PCP): _____ Phone number: _____
Pharmacy Number: _____ Date of last physical exam: _____

PERSONAL HEALTH HISTORY

Please circle all that apply:

General Diabetes high cholesterol, family history of cancer personal history of cancer, weight loss

Cardiovascular Chest pain, heart failure, heart murmur, vascular disease, blood clots, fainting, lower extremity edema, hypertension (High blood pressure)

Respiratory Sleep apnea, shortness of breath, asthma, bronchitis, pneumonia, allergies, hay ever

Gastrointestinal Lactose intolerance, gallbladder, gall stones, diarrhea, constipation

Genitourinary Prostate cancer- personal or family, overactive bladder/frequent urination, painful urination Decreased force of urination, on/off urine flow, incomplete emptying of bladder, prostate Enlargement/BPH, burning during urination, blood in urine, history of kidney or bladder Infection, kidney or bladder infection in the last 12 months, liver disease

Psychiatric History of depression

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers:

Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____

Allergies: _____ No Known Allergies
Or List Allergies and Reaction _____
_____

Surgeries:

Year _____ Surgery/Reason _____
Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: _____ Sedentary (No exercise) _____ Mild exercise _____ Occasional vigorous exercise _____ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week, etc.):

_____
_____

Health History Questionnaire

Health Habits and personal Safety

Alcohol: ____Yes Number of drinks per week: _____

____No

Tobacco: ____Yes _____ Cigarettes ____ Cigars ____ Chewing How man/much: _____

____No

Illicit drug use: ____Yes

____No

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased concentration ____ Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Moodiness ____ Yes ____ No

Depression ____ Yes ____No

Increasing fatigue ____ Yes ____No

Decreasing energy ____ Yes ____No

Daytime sleepiness ____ Yes ____ No

Poor sleep habits ____ Yes ____No

Erectile dysfunction ____ Yes ____ No

I have had testosterone checked previously _____ Yes ____ No

I have used testosterone previously ____ Yes ____ No

If yes, date(s): _____ Type: _____ Usage: _____

Patient Name (Print) _____ DOB: _____

Signature: _____ Date: _____

295 Molly Lane, Suite 150 Woodstock, GA 30189

Consent for Testosterone Replacement/ hCG Therapy/ No Other Therapy Agreement

Patient Name: _____ DOB: _____

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT/hCG THERAPY (TRT)

It is important to understand that medicine is an inexact science. Although we will carry out your treatment carefully, results may vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider. Please review the following statements, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all your questions to your satisfaction.

Directions: Initial beside each statement that you have read, understand and agree with.

_____**1.** This is my consent for Innovative Health and Wellness, including any physician or nurse who works with the company, to begin my treatment for Testosterone Replacement Therapy.

_____2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3-#7)

_____3. Extra fluid in the body- This can cause problems for patients with heart, kidney or liver disease.

_____4. Sleep disturbance- This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.

_____5. Prostate enlargement- this may cause problems with urinating.

_____6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____7. I understand that I will have periodic blood tests to monitor my blood levels.

_____8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____9. I have had an opportunity to discuss with Innovative Health and Wellness and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers.

_____10. I understand that the physical exam by Innovative Health and Wellness does NOT replace a full physical exam by a personal physician.

_____11. I agree to have my personal perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician, Innovative Health and Wellness will assist in locating one for me.

_____12. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility.

I, _____, agree that, while a patient of Innovative Health and Wellness, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by Innovative Health and Wellness during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Innovative Health and Wellness.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

ADAM questionnaire about symptoms of low testosterone

(Androgen Deficiency in Aging Male)

This basic questionnaire can be very useful for men to describe the kind and severity of their low testosterone symptoms.

1.	Do you have a decrease in libido (sex drive)?	Yes	No
2.	Do you have a lack of energy?	Yes	No
3.	Do you have a decrease in strength and/or endurance?	Yes	No
4.	Have you lost height?	Yes	No
5.	Have you noticed a decreased “enjoyment of life”	Yes	No
6.	Are you sad and/or grumpy?	Yes	No
7.	Are your erections less strong?	Yes	No
8.	Have you noticed a recent deterioration in your ability to Play sports?	Yes	No
9.	Are you falling asleep after dinner?	Yes	No
10.	Has there been a recent deterioration in your work performance?	Yes	No

If you answered yes to number 1 or 7 or if you answer yes to more than 3 questions, you may have low Testosterone.