Male BHRT Patient Information

Name:_____

Last First Middle

Today's Date:_____

Date of Birth:_____ Social Security #:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Numbers: Home:_____ Cell:_____

Email Address for office use only will not be shared:_____

Patient employed by:_____

Business Address:_____

Business Phone:_____

Marital Status:(Please circle) Married Divorced Single Widow Living with significant other

Spouse's Name:_____

Spouse's Date of Birth:_____Social Security #: _____

Spouse employed by:_____ Business Phone:_____

In case of emergency, whom should we notify:_____

Emergency Phone Numbers:_____

Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

Preferred method for appointment reminders:

- ☐ TEXT: #_____
- ☐ EMAIL: _____
- ☐ VOICEMAIL: #_____

*****Payment is due at time of service.*****

Payment accepted: Cash, Check, Visa, Mastercard, & Discover And now Care Credit

What is your primary health concern or reason for considering bio-identical hormone replacement therapy?

_____

_____

SEXUAL HISTORY

1. Are you sexually active? ☐ Yes ☐ No
2. Have you had the mumps? ☐ Yes ☐ No

   Date:_____
3. Have you had testicular cancer? ☐ Yes ☐ No

   Date:_____
4. Do you have prostate problems? ☐ Yes ☐ No

   If yes, please describe:_____
5. Have you had any bladder or kidney problems? ☐ Yes ☐ No

   If yes, when & treatment:_____
6. Do you have erectile dysfunction? ☐ Yes ☐ No

   If yes, please describe:_____
7. Do you have:

   Fatigue? ☐ Yes ☐ No

   Decrease of memory? ☐ Yes ☐ No

   Decrease of energy level? ☐ Yes ☐ No

   Decrease of sexual drive? ☐ Yes ☐ No
8. Do you suffer from:

   Anxiety ☐ Yes ☐ No

   Irritability? ☐ Yes ☐ No

   Mood swings? ☐ Yes ☐ No

   Migraines? ☐ Yes ☐ No
9. How have you dealt with these symptoms?

   _____

   _____

10. Is your sex drive the same as it was five years ago? □ Yes □ No

    Describe:_____

11. List any other sexual dysfunctions:

    _____

    _____

    _____

12. Have you experienced weight gain in the last one - two years? □ Yes □ No

    If yes, describe?_____

13. Have you lost greater than 10 pounds in less than a month? □ Yes □ No

    If yes, why?_____

14. Have you fathered any children? □ Yes □ No

    If yes, how many? _____

15. Have you had your Testosterone level taken? □ Yes □ No

    Date:_____

16. List current medications:

    _____

    _____

    _____

PAST MEDICAL HISTORY

1. Do you have diabetes? □ Yes □ No
2. Do you have/had hypertension? □ Yes □ No
3. Do you have heart disease? □ Yes □ No
4. Do you have a heart murmur? □ Yes □ No
5. Do you have/had kidney disease? □ Yes □ No
6. Have you ever been treated for psychiatric problems? □ Yes □ No
7. Have you ever had rheumatic fever? □ Yes □ No
8. Do you have mitral valve prolapse? □ Yes □ No
9. Have you ever had a urinary tract infection? □ Yes □ N
10. Have you ever had hepatitis/liver disease? □ Yes □ No

11. Have you ever had varicosities/phlebitis? ☐ Yes ☐ No
12. Do you have any thyroid problems? ☐ Yes ☐ No
13. Have you had any major accidents? ☐ Yes ☐ No
14. Have you ever had any blood transfusions? ☐ Yes ☐ No
15. Do you have asthma/lung disease? ☐ Yes ☐ No
16. Do you have lupus, Scleroderma or similar diseases? ☐ Yes ☐ No

    If yes, please describe:_____

17. Do you have arthritis? ☐ Yes ☐ No

    If yes, what type:_____

18. Do you have any Drug Allergies? ☐ Yes ☐ No

    If yes, please list:_____

19. List any surgeries:

    _____

    _____

20. List any other operations/hospitalizations (include year & reason):

    _____

    _____

21. Have you had any anesthesia complications? ☐ Yes ☐ No

    If yes, please list:_____

22. Have you ever been anemic? ☐ Yes ☐ No
23. Do you have an Internist or Family Doctor? ☐ Yes ☐ No

    If yes, please list name and phone number:_____

24. Have you had your cholesterol checked? ☐ Yes ☐ No

    If yes, date last checked:_____

    Was it normal? ☐ Yes ☐ No

SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ Yes ☐ No

    If yes, number per day?_____ Number of years?_____

2. Do you drink alcohol? ☐ Yes ☐ No

    If yes, how much per day?_____

Rejuvené

MALE
SYMPTOM CHECKLIST

Name: _____ **Date:** _____

Which of the following symptoms apply to you at this time? Please mark the appropriate oval for each symptom.

		Frequently	Rarely	Never
1.	**Excessive sweating**	⬭	⬭	⬭
2.	**Night Sweats**	⬭	⬭	⬭
3.	**Depression**	⬭	⬭	⬭
4.	**Irritability**	⬭	⬭	⬭
5.	**Anxiety**	⬭	⬭	⬭
6.	**Decreased energy**	⬭	⬭	⬭
7.	**Decreased sexual desire**	⬭	⬭	⬭
9.	**Erectile Dysfunction**	⬭	⬭	⬭
10.	**Decrease in morning erections**	⬭	⬭	⬭
11.	**Muscle or joint pain**	⬭	⬭	⬭
12.	**Sleeping Problems**	⬭	⬭	⬭

13.	**Difficulty concentrating**	⬭	⬭	⬭
14.	**Foggy thinking**	⬭	⬭	⬭
15.	**Mood swings**	⬭	⬭	⬭
16.	**Migraines**	⬭	⬭	⬭
17.	**Decreased stamina**	⬭	⬭	⬭
18.	**Cold body temperature**	⬭	⬭	⬭
19.	**Difficulty losing weight**	⬭	⬭	⬭
20.	**Prostate problems**	⬭	⬭	⬭
21.	**Elevated triglycerides**	⬭	⬭	⬭
22.	**Elevated cholesterol**	⬭	⬭	⬭
23.	**Decrease in beard growth**	⬭	⬭	⬭

Do you have any other major symptoms? **Yes** ⬭ **No** ⬭

If yes, please describe:

_____

_____

_____

_____

_____

Rejuvené

Acknowledgement of Rejuvene's Policy on Insurance Billing

Unlike most medical practices, Rejuvene does not have an insurance or billing department. Because we have chosen to not engage in insurance or patient billing, we do not have to carry the expense that an insurance/patient billing department incurs - an expense that is ultimately passed down to the patient. This is why we require payment at the time of service.

As a patient of Rejuvene, you are free to submit your own claim to your insurance provider, although in our experience, common insurance providers do not reimburse for BHRT. Most insurance companies are used to reimbursing claims to the physician practice, and therefore make many inquires directly to the physician, requesting medical records and other documentation. Because we do not have an insurance/billing department to handle these requests, we leave the management of your claim to you. If you need copies of your medical records to assist your insurance provider in processing your claim, we are happy to assist you upon receipt of a written request from you our patient (please allow 7-10 days for processing).

I acknowledge that I have reviewed the above stated policy.

Patient Signature **Date**