Today's Date: ___/___/_____

Male New Patient Information

Name: ______________________ DOB: ______________ Height: ____________

Street Address: ______________________ City/St/Zip: ______________________

Phone Number: ______________ Email: ______________ SSN:______________

Occupation: ______________________ Employer/Title: ______________________

Work Phone: ______________ Work Address: ______________________

How did you hear about us: ____

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

Children (Please Circle): Biological Adopted Step Children None

Do you desire more children (Please Circle): Yes No

Emergency Contact Information:

Name: ______________________ Relationship: ______________________

Phone: ______________________ Address: ______________________

Primary Care Physician:

Name: ______________________ Phone Number: ______________________

Address: ______________________ City/St/Zip: ______________________

Preferred Pharmacy:

Name: ______________________ Phone Number: ______________________

Address: ______________________ City/St/Zip: ______________________

Please List all Current Medications and Doses:

______________________/______________________

______________________/______________________

______________________/______________________

Please list any known drug allergies (or write no known allergies): ______________________

Are you currently or have you ever used any form of Testosterone or Hormone Therapy:

Please Circle: Never Used Gel Cream Shots Pellets Other

Main Concerns/ Reason for Visit:

- ☐ Fatigue
- ☐ Decreased Libido
- ☐ Erectile Dysfunction
- ☐ Decreased Muscle Mass
- ☐ Weight Concerns
- ☐ Mood Concerns
- ☐ Other:______________________________

When was your last physical examination: ______________________________

When was your last prostate exam/evaluation: ______________________________

Symptom Checklist

Please Circle the Change in Severity of Each of the Following Classifications:

Metabolic:				
Weight gain:	Yes	No	# of Pounds in past year: ___	
Increased blood pressure:	None	Mild	Moderate	Severe
Increased blood sugar:	None	Mild	Moderate	Severe
Musculoskeletal:				
Decrease in muscle size, tone, strength:	None	Mild	Moderate	Severe
Decrease in physical capabilities/performance:	None	Mild	Moderate	Severe
Mental function:				
Fatigue, especially in afternoon:	None	Mild	Moderate	Severe
Decrease in mental sharpness:	None	Mild	Moderate	Severe
Sexual function:				
Lack of morning erections:	None	Mild	Moderate	Severe
Decreased libido:	None	Mild	Moderate	Severe
Erectile Dysfunction:	None	Mild	Moderate	Severe

Medical History

(Do you have or have you had any of the following)

ADHD:	Yes	No
AIDS/HIV:	Yes	No
Acid Reflux:	Yes	No
Acne:	Yes	No
Allergies:	Yes	No
Anemia:	Yes	No
Anxiety Disorder:	Yes	No
Arthritis:	Yes	No
Asthma:	Yes	No
Bladder problems:	Yes	No
Blood Diseases:	Yes	No
Blood transfusions:	Yes	No
Bone problems:	Yes	No
Breast Cancer:	Yes	No
Cancer:	Yes	No
If Yes, Please explain: ______________________		
Cardiomyopathy:	Yes	No
Colon Cancer:	Yes	No
Colon Polyps:	Yes	No
Congestive heart failure:	Yes	No
Constipation:	Yes	No
COPD:	Yes	No
Coronary Artery Disease:	Yes	No
Depression:	Yes	No
Diabetes:	Yes	No
Eczema:	Yes	No
Fatigue:	Yes	No
Fibromyalgia:	Yes	No
GI Problems:	Yes	No
Hair loss:	Yes	No

Headaches/Migraines:	Yes	No
Heart attack:	Yes	No
Heart murmur:	Yes	No
Heart Problems:	Yes	No
Hepatitis:	Yes	No
High blood pressure:	Yes	No
High Cholesterol:	Yes	No
High Iron:	Yes	No
Hyperthyroidism:	Yes	No
Hypothyroidism:	Yes	No
Infertility:	Yes	No
Joint problems:	Yes	No
Kidney Disease:	Yes	No
Kidney stones:	Yes	No
Leukemia:	Yes	No
Liver disease:	Yes	No
Lung Disease:	Yes	No
Mental Disorder:	Yes	No
Muscle Problems:	Yes	No
Osteoporosis:	Yes	No
Prostate Cancer:	Yes	No
Rectal cancer:	Yes	No
Seizures/ Epilepsy:	Yes	No
Sleep Apnea:	Yes	No
Snoring:	Yes	No
Stroke:	Yes	No
Varicosities:	Yes	No
Water retention:	Yes	No
Other: ______________________________		

Surgical History:

- ☐ Appendectomy
- ☐ Back surgery
- ☐ Colonoscopy
- ☐ Gall bladder removal
- ☐ Knee surgery
- ☐ Rhinoplasty
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Wisdom teeth removal
- ☐ Other Surgeries: ____________________

Have you ever had any anesthesia complications: _____ Yes _____ No

If yes, explain: ____

Family History (HX):

(Please Circle Yes/No)

Do you have a family history of prostate cancer:	Yes	No	If yes, who: ____________________
Do you have a family history of colon cancer:	Yes	No	If yes, who: ____________________
Do you have a family history of heart disease:	Yes	No	If yes, who: ____________________
Do you have a family history of heart attacks:	Yes	No	If yes, who: ____________________
Do you have a family history of diabetes:	Yes	No	If yes, who: ____________________
Do you have a family history strokes:	Yes	No	If yes, who: ____________________
Do you have family history delayed puberty:	Yes	No	If yes, who: ____________________
Do you have a family history of reproductive disorders:	Yes	No	If yes, who: ____________________

Social History:

(Please Circle Yes/No)

Have you ever smoked cigarettes: Yes No — Do you currently smoke cigarettes: Yes No

If yes, how many on average per day: ____________ — How many years have you been smoking: ________________

Do you chew or dip tobacco: Yes No — If yes, how many times per day: ____________________

Do you use recreational drugs: Yes No — If yes, please explain: __________________________

Do you drink alcohol: Yes No — If yes, how many drinks do you average a week: __________

Do you exercise: Yes No — Do you consume caffeine: Yes No

Review of Systems

(Please Circle Yes/No)

Constitutional:

Abnormal weight gain:	Yes	No
Night sweats:	Yes	No
Decreased appetite:	Yes	No
Fatigue:	Yes	No

Eyes:

Sudden vision changes:	Yes	No
Double vision:	Yes	No
Visual disturbances:	Yes	No

Ear/Nose/Throat:

Hearing loss:	Yes	No
Ringing in ears:	Yes	No
Altered sense of smell:	Yes	No

Chest:

Nipple tenderness:	Yes	No
Breast enlargement:	Yes	No

Respiratory:

Persistent cough:	Yes	No
Wheezing:	Yes	No
Shortness of breath:	Yes	No

Cardiovascular:

Chest pain/pressure:	Yes	No
Palpitations:	Yes	No
Pain in the lower legs:	Yes	No
Fainting spells:	Yes	No
Dizziness:	Yes	No

Genitourinary:

Urinary frequency:	Yes	No
Urinary hesitancy:	Yes	No
Dribbling after urination:	Yes	No
Pain with urination:	Yes	No
Blood in urine:	Yes	No
Erectile dysfunction:	Yes	No
Decreased sex drive:	Yes	No

Gastrointestinal:

Abdominal pain:	Yes	No
Nausea/vomiting:	Yes	No
Change in bowel habits:	Yes	No
Change in appetite:	Yes	No
Blood in stool:	Yes	No

Neurological:

Frequent headaches:	Yes	No
Arms and/or leg weakness:	Yes	No
Difficulty with speech:	Yes	No
Chronic pain:	Yes	No

Musculoskeletal:

Joint pain:	Yes	No
Muscle pain:	Yes	No
Muscle weakness:	Yes	No

Integumentary:

Suspicious skin lesions:	Yes	No
Recurrent rashes:	Yes	No
Acne:	Yes	No

Psychiatric:

Depressed mood:	Yes	No
Anxiety:	Yes	No
Irritability:	Yes	No
Insomnia:	Yes	No
Low self-confidence:	Yes	No

Endocrine:

Decreased libido:	Yes	No
Hot/Cold intolerance:	Yes	No
Appetite change:	Yes	No
Excessive thirst:	Yes	No

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: ______________________________ **TODAY'S DATE:** _____________

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** __________

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Financial Responsibility

Please sign your name by whichever statement is true:

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Please choose which option below best fits you:

* I do not have Insurance and will be paying out of pocket for all services rendered. I understand that I will be paying 100% of all services rendered.

____

Signature/Date

* I have insurance and give Paradigm Hormones permission to bill said insurance company for all treatment taken. I also understand that I will be responsible to all charges not paid by my insurance company.

____

Signature/Date

* I have insurance but would prefer Paradigm Hormones not bill to my insurance company. I understand that I will be responsible 100% for all services rendered.

____

Signature/Date

*I have insurance but understand that only my office visit and labs will be billed out and I will be responsible to the rest of the charges, including 100% of the pellet cost.

____

Signature/Date

Consent to Have Blood Drawn:

I authorize the medical staff of Paradigm Hormones LLC to obtain a blood sample for the purpose of running any laboratory testing they deem necessary as determined in the professional discretion of the medical staff.

____

Signature/Date

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Paradigm Hormones.

____

Signature/Date

Consent to Order Medical/Prescription History

I authorize the medical staff of Paradigm Hormones LLC to obtain my past medical and prescription history. In order to help with my treatment.

____

Signature/Date

Consent to Contact

I give consent to Paradigm Hormones to contact me to discuss different aspects of my visits. I understand that some of the reasons they may be contacting me is to discuss lab results, appointment reminders, billing etc.

____

Signature/Date

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** __________
Today's Date:______________ **Health Care Provider:**______________________

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (Check all that apply to you or your family)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at or under age 45*
- ☐ Ovarian cancer at any age*
- ☐ Two primary breast cancers in the same person with one diagnosed at or under age 50*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Three relatives on the same side of the family with breast and/or ovarian cancer at any age
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

- ☐ A personal history of colon/rectal cancer or endometrial cancer diagnosed at or under age 50
- ☐ A personal history of two or more Lynch syndrome cancers***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age

- ☐ A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling

Patient's Signature:______________________________ Date: ______________
Health Care Provider's Signature: ______________________ Date: ______________

For Office Use Only:
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment:______________
Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Request for Release of Protected Health Information (HIPAA)

This form will be used to release your protected health information as required by federal and state privacy laws. Your authorization allows Paradigm Hormones to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Paradigm Hormones. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Your Information:

Name: ______________________________

Address: ______________________________

City/St/Zip: ______________________________

Date of Birth: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

SSN: ____________________

I authorize my physicians, medical professionals, Paradigm Hormones, and its agents and affiliates to release my protected health information as described below:

Recipient: ______________________________

Relationship: ____________________ Phone Number: ____________________

Address: ______________________________

City/St/Zip: ______________________________

Manner of Release:

- ☐ Records shall be made available for Pick-up only.
- ☐ Records shall be mailed to recipient to: ____________________
- ☐ Records shall be faxed to recipient to: ____________________
- ☐ Records shall be emailed to recipient : ____________________
- ☐ Any of the above

Description of Information to be released:

- ☐ All information related to the provision of payment for my healthcare benefits or services.
- ☐ Specific information as described on the line: ____________________

Purpose of Release:

____

____

This authorization will expire (Check only one box)

- ☐ When I revoke this authorization
- ☐ Up the following date, event or condition: ______________________

Information regarding approval:

You or your personal representative must sign and date this form in order for it to be complete. A personal representative is a person who authorizes the release of protected health information and has the legal authority to act on behalf of an individual. To release information to a personal representative, we must have a copy of a power of attorney or other legal document on file at the time of the request to release information to the personal representative.

Affirmation and Request for Release of Information:

"I affirm all the foregoing and information supplied herein is true and correct. I further understand that this authorization to release information voluntary and is not a condition of treatment, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. I request that Paradigm Hormones release the protected health information described above to the persons and/or entities listed above for the purposes set forth above."

______________________________ ______________

Signature **Date**