NEW VITALITY CENTER FOR MEN
BE YOURSELF AGAIN

Dear Patient:

You've made the right choice towards getting your life back on track. Pellets are a superior and remarkable method of Bio-Identical Hormone Replacement Therapy (BHRT). This type of therapy has been documented and researched in medical journals since 1939. Not only will you regain the energy, libido and vitality of your youth; we are here to help you get back to your normal physiological state of well-being. Won't that be a welcome relief?

Your appointment is scheduled on:

Day & Date:_____ Arrival Time: _____ Time: _____

Provider: _____ Location: _____

Please notify us 48 hours in advance of a cancellation

Inside your packet, we've enclosed many pages for you to fill out and ones filled with information.

Lab work: Please go to the lab location we have provided for you *within the next few days* to ensure that your lab results are available by your scheduled appointment date. Please check with your insurance carrier prior to receiving your lab work to find out if your insurance covers the lab work. If you have a high deductible or your insurance does not cover your lab work, please call your provider's office for price ranges. This is a fasting test; please fast for 8-10 hours before your lab work. You may walk into the lab facility without an appointment.

Special N o t e : If you are a Medicare/HMO patient, it is important that you ask your current Medicare/HMO provider to complete their lab form with our necessary lab work. Medicare/HMO may or may not cover your lab work charges. In addition, **please complete all the enclosed new patient forms and bring them with you to your appointment.**

Pages to fill out and bring with you to your appointment. Please do not put them in the mail or fax.

- ☐ **Male Patient Questionnaire**
- ☐ **Patient Consent to Leave Detailed Message**
- ☐ **Medicare Non-Assigned Form** (if applicable)
- ☐ **Authorization for Release of Information**
- ☐ **Acknowledgement Form**

Along with a copy of your most recent:

- ☐ **Proof of yearly prostate exam**

We look forward to seeing you soon.

Here's to your well being!

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MALE PATIENT INFORMATION

Name: _____ Today's Date: MM/DD/YYYY
LAST FIRST MIDDLE

Date of Birth: MM/DD/YYYY

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _

LAST FIRST MIDDLE

Spouse's Date of Birth MM/DD/YYYY

Spouse's Employer: _

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____

Contact Information: _____
HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: MM/DD/YYYY

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What is the reason for your visit today? Please describe the symptoms & be specific:

How did you hear about us:

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Prostate & Testicular History

Age of first intercourse experience: _____

Are you currently sexually active: ☐ YES ☐ NO

Have you had any sexually transmitted diseases (STDs): ☐ YES ☐ NO

Please list: _____

Have you had a sperm count: ☐ YES ☐ NO
What were the results of the sperm count: _____

Have you had the mumps: ☐ YES ☐ NO
When did you have the mumps: _____

Have you ever had testicular cancer: ☐ YES ☐ NO
What type of treatment did you receive: _____

Do you have prostate problems: ☐ YES ☐ NO

Do you have or have you had prostatitis: ☐ YES ☐ NO

Is your prostate enlarged: ☐ YES ☐ NO

Have you ever had prostate cancer: ☐ YES ☐ NO
What type of treatment did you receive: _____

Have you had blood in your urine: ☐ YES ☐ NO
If yes, when did this occur: _____
Please describe treatment used: _____

Do you have bladder or kidney issues: ☐ YES ☐ NO
If yes, please describe current treatment, if any: _____

Do you have erectile dysfunction: ☐ YES ☐ NO
If yes, please describe: _____

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Are you suffering from the following (please check all that apply)

Fatigue:	☐ YES	☐ NO
Decrease of memory:	☐ YES	☐ NO
Decrease in energy level:	☐ YES	☐ NO
Decrease in sexual desire:	☐ YES	☐ NO

Are you suffering from the following (please check all that apply)

Anxiety:	☐ YES	☐ NO
Irritability:	☐ YES	☐ NO
Mood swings:	☐ YES	☐ NO
Migraines:	☐ YES	☐ NO
Memory loss:	☐ YES	☐ NO
Foggy thinking:	☐ YES	☐ NO
Muscle loss:	☐ YES	☐ NO
Poor response to exercise:	☐ YES	☐ NO
Poor recovery from exercise:	☐ YES	☐ NO

Please describe the way in which these issues have been dealt with:

_____

_____

_____

_____

Do you initiate intercourse:	☐ YES	☐ NO
Is intercourse satisfying:	☐ YES	☐ NO
Do you achieve orgasm:	☐ YES	☐ NO
Do you suffer from premature ejaculation:	☐ YES	☐ NO
How often do you have intercourse:	_____	
Is your sex drive similar as it was five years ago:	☐ YES	☐ NO

Please describe:

_____

_____

List any other sexual dysfunctions:

_____

_____

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Have you experienced weight gain in the last 1-2 years: ☐ YES ☐ NO

If yes, please describe: _____

_____

_____

Have you lost more than 10 pounds in less than a month: ☐ YES ☐ NO

If yes, why: _____

Have you ever been tested for HIV/AIDS: ☐ YES ☐ NO

Are you HIV positive: ☐ YES ☐ NO

If yes, when did this occur: _____

Please describe:

_____

_____

Have you fathered any children: ☐ YES ☐ NO

If yes, how many: _____

Have you ever had your testosterone level taken in the past: ☐ YES ☐ NO

If yes, why: _____

Please check the box that best describes your sexual orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual

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MEDICALHISTORY

Do you have **diabetes**: ☐ YES ☐ NO

Do you have or have you ever had **hypertension**: ☐ YES ☐ NO

Do you have **heart disease**: ☐ YES ☐ NO

Have you ever had a heart attack or stroke: ☐ YES ☐ NO

Have you ever had lung cancer: ☐ YES ☐ NO

If yes, please describe treatment used: _____

_____

Have you ever had colon polyps: ☐ YES ☐ NO
If yes, please describe treatment used: _____

_____

Have you ever had stomach/intestinal cancer: ☐ YES ☐ NO

If yes, what type: _____
Please describe treatment used: _____

Have you ever had leukemia or lymphoma: ☐ YES ☐ NO

If yes, what type: _____
Please describe treatment used: _____

_____

Do you have a **heart murmur**: ☐ YES ☐ NO

Do you have or have you ever had **kidney disease**: ☐ YES ☐ NO

Have you ever been treated for a **psychiatric disorder**: ☐ YES ☐ NO

If yes, please name the disorder: _____

Have you ever had **rheumatic fever**: ☐ YES ☐ NO

Do you have **mitral valve prolapse**: ☐ YES ☐ NO

Have you ever had a **urinary tract infection**: ☐ YES ☐ NO

Have you ever had **hepatitis**: ☐ YES ☐ NO

If yes, please check which type:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had **liver disease**: ☐ YES ☐ NO

Have you ever had **varicose veins**: ☐ YES ☐ NO

Have you ever had **phlebitis**: ☐ YES ☐ NO

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Do you have any **thyroid problems**: ☐ YES ☐ NO

If yes, please check the problem:

☐ Low Function ☐ Overactive ☐ Goiter ☐ Hashimoto

Have you ever had a **blood transfusion**: ☐ YES ☐ NO

Do you have a **lung disease**: ☐ YES ☐ NO

Do you have **asthma**, **emphysema** or **chronic bronchitis**: ☐ YES ☐ NO

Do you have **lupus, scleroderma, collagen disease**: ☐ YES ☐ NO

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Have you had any **major accidents**: ☐ YES ☐ NO

Do you have any **drug allergies**: ☐ YES ☐ NO

If yes, please list the drugs you are allergic to: _____

_____

Have you ever had any problems with your blood ☐ YES ☐ NO
If yes, please list the blood problems (such as anemia and excess blood cells: _____

_____

Have you ever had multiple myeloma: ☐ YES ☐ NO
Please describe treatment used: _____

Please list all operations/hospitalizations (including year and reason):

_____

_____

_____

_____

Have you ever had any anesthesia complications: ☐ YES ☐ NO

If yes, please explain: _____

_____

Do you have an Internist or Family Physician: ☐ YES ☐ NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____

Are you currently taking any medications: ☐ YES ☐ NO

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Please list the medications you are currently taking and the dosage amount:

_____

_____

Have you ever had your cholesterol checked: ☐ YES ☐ NO

If yes, what was the date it was last checked: _____

How was your cholesterol: ☐ Low ☐ Normal ☐ High

SOCIALHISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please to try list the number you smoke per day on average: _____

Please list the number of years you have been smoking: _____

Do you use recreational drugs: ☐ YES ☐ NO

Do you drink alcohol: ☐ YES ☐ NO

If yes, what type of alcohol do you drink: _____

How many drinks **per week** , on average, do you drink: _____

Are you using any form of Testosterone or Hormone Therapy: ☐ YES ☐ NO

If yes, please check which type:

☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

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Male Hormone Symptom Diary

Name: _____

SYMPTOMS: Rate 1-10 (10 is the worst)	Before Treatment Date:	Month #1 Date:	Month #2 Date:	Month #3 Date:	Month #4 Date:	Month #5 Date:	Month #6 Date:
Fatigue							
Sleep Problems							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Decrease in beard growth							
Depression							
Anxiety							
Muscle Weakness							
Excessive Sweating							
Nervousness							
Decrease in Muscle Strength							
Muscle Pain							
Joint Pain							
Foggy Mind							
Loss of Well Being							
Poor Results from Exercise							
Night Sweats							

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Symptom Questionnaire

Patient Name: _____ Today's Date: _

Date of Birth: _____

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0= you never experience the symptom
5= you experience the symptom severely and all the time

Dermatological

Dry Skin	__/5
Course Skin	__/5
Itchy Skin	__/5
Dry, course hair	__/5
Thinning/loss of hair	__/5
Thinning eyebrows	__/5
Brittle or ridges on nails	__/5
Excess wax in ears	__/5
Decreased sweat	__/5
Paleness of skin or lips	__/5
TOTAL	**__/50**

Metabolism

Lethargy (low energy)	__/5
Sensation of cold	__/5
Heat intolerance (not hot flashes)	__/5
Slow speech (non memory)	__/5
Weight gain with little food intake	__/5
Lack of appetite	__/5
Lack of libido	__/5
TOTAL	**__/30**

Dryness (sicca)

Dry eyes	__/5
Dry skin	__/5
Dry mouth	__/5
Dry nose	__/5
Dry sinuses	__/5
Dry vagina	__/5
TOTAL	**__/30**

Gastrointestinal

Constipation	__/5
Diarrhea	__/5
Irritable bowel syndrome	__/5
GERD (reflux disease)	__/5
TOTAL	**__/20**

Reproductive

Delayed menstrual flow	__/5
Excessive menstrual flow	__/5
Painful menses	__/5
Impotence (men only)	__/5
TOTAL	**__/20**

Mental/Emotional Well-being

Depression	__/5
Irritability/mood swings	__/5
Nervousness	__/5
Anxiety	__/5
Impaired memory	__/5
Impaired focus	__/5
TOTAL	**__/30**

Cardiovascular/Respiratory

Chest pain	__/5
Palpitations	__/5
Atrial fibrillation	__/5
Chronic cough of *unknown reason*	__/5
Airflow obstruction (non smokers)	__/5
Shortness of breath on physical exertion	__/5
Shortness of breath in general	__/5
TOTAL	**__/30**

Swelling

Swollen ankles	__/5
Swollen wrists	__/5
Swollen eyelids	__/5
Swollen, thick tongue	__/5
Swollen face	__/5
TOTAL	**__/25**

Musculoskeletal

Muscle weakness	__/5
Unexplained tingling or Numbness	__/5
Body aches	__/5
Muscle pain	__/5
Joint pain	__/5
Carpal tunnel syndrome	__/5
Plantar fasciitis	__/5
TOTAL	**__/35**

Sleep

Difficulty getting to sleep	__/5
Difficulty staying asleep	__/5
Wake unrefreshed	__/5
Sleep apnea	__/5
Snoring	__/5
TOTAL	**__/25**

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
__Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
__Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
__Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)

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