

## MALE PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about us? ☐ Patient (Name: \_\_\_\_\_) ☐ Event ( \_\_\_\_\_ )

☐ Practitioner (Name: \_\_\_\_\_) ☐ Pharmacy (Name: \_\_\_\_\_)

☐ Social Media (Type: \_\_\_\_\_) ☐ TV (Station: \_\_\_\_\_) ☐ Radio (Station: \_\_\_\_\_)

☐ Web (Keyword Searched: \_\_\_\_\_) ☐ Signage (\_\_\_\_\_)

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

May we share your clinical information with your PCP? ☐ Yes ☐ No

## MEDICAL HISTORY

Weight: \_\_\_\_\_ Have you ever had any issues with anesthesia? ( ) Yes ( ) No

Any known drug allergies: ( ) Yes ( ) No If yes please explain: \_\_\_\_\_

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? \_\_\_\_\_ How often? \_\_\_\_\_ Age started? \_\_\_\_\_

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? \_\_\_\_\_ How often? \_\_\_\_\_ Age started? \_\_\_\_\_

Current Medications and dosage: \_\_\_\_\_

Nutritional/Vitamin Supplements: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_ Past HRT: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other \_\_\_\_\_

Do you have a personal history of? Check all that apply.

( ) High blood pressure                      ( ) Hemochromatosis                      ( ) Trouble passing urine or take Flomax or Tamsulosin

( ) High cholesterol

( ) Heart disease                      ( ) Psychiatric disorder                      ( ) Prostate enlargement

( ) Stroke

( ) Diabetes

( ) Prostate enlargement

( ) Elevated PSA

( ) Heart attack                      ( ) Thyroid disease                      ( ) Cancer:

( ) Blood clot or pulmonary emboli ( ) Arthritis ( ) Testicular or prostate Year:

( ) Testicular or prostate      Year: \_\_\_\_\_

( ) Other: \_\_\_\_\_ Year: \_\_\_\_\_

***I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.***

PRINT NAME \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

DATE \_\_\_\_\_



Name \_\_\_\_\_  
DOB \_\_\_\_\_

**Maricopa Wellness Center  
AMS Checklist - BEFORE HRT**

**Which of the following symptoms apply at this time?**

**Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.**

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Increased need for sleep, often feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Irritability (feeling aggressive, easily upset about little things, moody)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervousness (inner tension, restlessness, feeling fidgety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Anxiety (feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Decrease in muscular strength (feeling of weakness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling that you have passed your peak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feeling burnt out, having hit rock-bottom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Decrease in beard growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Decrease in ability/frequency to perform sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Decrease in the number of morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please share any additional comments about your symptoms you would like to address.**

**Please list any prior hormone therapy?**

**Recent PSA:** \_\_\_\_\_ **Recent Digital Rectal Exam (Date):** \_\_\_\_\_ **Normal / Abnormal**

**History of Prostate problems or Biopsy. If so, please provide details.**

Date \_\_\_\_\_





## Maricopa Wellness Center

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### Your Information. Your Rights. Our Responsibilities.

#### Your Rights

**You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### Your Choices

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide mental health care

#### Our Uses and Disclosures

**We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

I acknowledge receipt and understanding of my rights.

PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



## HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguard to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov).

We have adopted the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI and other documents or information.
2. It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, US mail, text, or any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology, as well as our office promotional material that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide client's access to their records in accordance with state and federal laws
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, \_\_\_\_\_ date \_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: \_\_\_\_\_



## Patient Consent for Release of Protected Health Information (PHI)

I, \_\_\_\_\_, give my consent to Maricopa Wellness Center to release my protected health information (PHI) to include, but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information, etc. to the following individuals:

\_\_\_\_\_  
Name (Print Clearly)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name (Print Clearly)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name (Print Clearly)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Consent (check ALL that apply):

I consent Maricopa Wellness Center to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results or financial services at the following [check ALL that apply]:

☐ Call

☐ Text

Phone: \_\_\_\_\_

☐ Email address: \_\_\_\_\_

\_\_\_\_\_  
This consent will expire only with written notification to [office@maricopawellness.com](mailto:office@maricopawellness.com)

Patient Name (Print Clearly): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
If a minor (under 18 years of age)

Parent or Guardian Name (Print Clearly): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Statement of Patient Financial Responsibility

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Maricopa Wellness Center** appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We expect these payments at time of service. I agree to **Maricopa Wellness Center** the full and entire amount of treatment given to me or to the above named patient at each visit.

We only accept insurance as a form of payment for lab work. You have the choice to file with your insurance or pay our cost. If you choose to file with your insurance for lab work instead of paying our cost you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage.

I understand and take full responsibility for any amounts not covered by my insurance provider. \_\_\_\_\_ Initials

We provide paperwork for some services that you can use to submit to your insurance company for reimbursement. We are unable to assist with any additional paperwork or requests made by patients or insurance providers.

Some prescriptive medication requires a payment prior to being ordered or dispensed in office. It is the responsibility of the patient to pick up the prescription from the office or personal mailbox/home. I understand there are no refunds, for any reason, on prescription medication. \_\_\_\_\_ Initials

I understand that refunds or credits are not permitted on **any** prescriptive medication, product, supplement or service provided by, or sold by, **Maricopa Wellness Center**. All sales are final. \_\_\_\_\_ Initials

I have read the above policy regarding my financial responsibility to **Maricopa Wellness Center** for providing any and all services to me, or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor Name (required for patients < 18 years)

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

### Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call at least 24-hours prior to cancel your appointment.

I understand if I *no show* or *cancel* an appointment without notifying **Maricopa Wellness Center** within 24 hours, I will have to pay a \$50 non-refundable fee before scheduling again. \_\_\_\_\_ Initials

I have read and understand the above information, and I agree to the terms described:

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor Name (required for patients < 18 years)

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date