MONTANO
WELLNESS LLC
Internal Medicine

Dear Patient

We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice, as well as instructions on completion of our new patient packet.

At Montano Wellness LLC, we practice preventative medicine as well as caring for your chronic and acute medical needs. Our practice philosophy is to try for early detection, early intervention, and prevention. Regularly scheduled office visits allow us to better assist you in identifying and managing any chronic health problems you may have. We believe this is in your short and long-term best interest. Being proactive about your health care can help us prevent and/or prolong the onset of future health problems as you age. We firmly believe, and our experience has shown it to be true, that those patients who are consistent in keeping their appointments have fewer episodes of acute illness, difficulty with unstable chronic illnesses, and generally continue to enjoy better health overall.

Included with this letter is our new patient packet that we ask to be completed prior to your first appointment with us to ensure a timely visit. Please complete to the best of your ability:

- □ The medical history questionnaire
- □ Your demographic information
- □ Screening questionnaires

A HIPPA privacy and release of information authorization will be signed upon arrival for your first visit. To add other individuals to your HIPPA authorization, please request an additional form.

We utilize an automatic calling system that will call you 48 hours in advance of your appointment, as a reminder. Please bring with:

- □ Your health insurance cards
- □ Driver's license or photo ID
- □ A list of your current medications

Thank you for allowing us to assist you with your health care needs If you have any questions or concerns, please do not hesitate to contact our office.

Sincerely,

C. Brendan Montano M.D
Owner, Medical Director

160 West Street, Suite 1A
Cromwell, CT 06416
(860) 632-0144
www.mdmontano.com

MONTANO WELLNESS LLC

Internal Medicine

160 West Street, Suite 1A
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P: (860) 632-0144
F: (860) 632-7882

DEMOGRAPHIC INFORMATION						
Name:						
	First		Middle		Last	
Address:						
	Street Address					
	City		State		ZIP	
Date of Birth		SSN		Gender	M F	

CONTACT INFORMATION			
Home Phone		Email Address	
Cell Phone		Emergency Contact Name	
Work Phone		Emergency Contact Number	
☐ I would like to receive text message reminders for appointments and balances			

MEDICAL INFORMATION			
Preferred Pharmacy			
	Pharmacy		Location
Preferred Laboratory	◘ Middlesex Hospital ◘ Quest Diagnostics ◘ Other: _____	Preferred Network for Specialist Referrals	◘ No Preference ◘ Middlesex Hospital Network ◘ Hartford Hospital Network ◘ UConn Network ◘ St. Francis Hospital Network ◘ Other: _____
Do you have any allergies?			
Do you take any medications or over the counter supplements?			

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Authorization for Access/Release of Information

Legal Name: _____ _____ _____
(Last) (First) (M.I.)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Address: _____
(street or box#, city, state, zip)

This information is to be used for the purpose of:		
□ Personal Use	□ Disability	□ Other: _____
□ Continuing Care	□ Workers Comp	_____
□ Legal	□ Transfer of Care	_____

I hereby authorize Montano Wellness LLC and C. Brendan Montano M.D. to:	
□ **RELEASE** information from my medical record **TO**:	□ **OBTAIN** information **FROM**:

Name: _____

Address: _____
(street or box#, city, state, zip)

Phone: _____ **Fax:** _____

Medical Information Requested		
□ Complete Medical Record		
□ History & Physical Exam/HP	□ Lab Results	□ Stress Test
□ Discharge Summary/DS	□ Radiology Report	□ Echocardiogram/EKG
□ Emergency Visits/ED	□ Pathology Report	□ Pulmonary Function Test
□ Operative/Procedure Report	□ Immunization Record	□ PT/OT/Speech Notes
Date(s) of Service:	□ All □ Specific Time Period: _____ – _____	

*****HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below.

Indicate which you do NOT want released with your records:		
□ HIV	□ Genetic Testing	□ Other: _____
□ Substance Abuse (which includes Alcohol & Drug Abuse)	□ Behavioral Health/Psychiatric	_____
□ Pregnancy Test	□ Sexually Transmitted Disease	_____

I understand that this authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting our office in writing. Cancellation of the authorization will not apply to information that has already been released based on this authorization.

_____
Printed Name

_____ _____
Signature **Date**

MEDICAL QUESTIONNAIRE

Name _____ Age _____ Single / Married / Divorced / Widow(er) _____ Date _____

Occupation _____ All previous occupations _____

Birth Place _____ Birthdate _____ List all States in which you have lived _____

Education _____ years High School _____ years College _____ years Post Grad

Date of last physical examination

Please list all Symptoms

1. _____
2. _____
3. _____
4. _____
5. _____

Routine check-up—no symptoms ☐

P.I. Please do not write in this space

	If Living		If Deceased	
	Age	Health	Age of death	Cause
Father				
Mother				
Brother or Sister 1.				
2.				
3.				
4.				
5.				
Husband or Wife				
Son or Daugher 1.				
2.				
3.				
4.				
5.				
6.				

Has any blood relative ever had	Please encircle yes or no		Who
Cancer	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Heart Trouble	Yes	No	
High blood pressure	Yes	No	
Stroke	Yes	No	
Epilepsy	Yes	No	
Insanity	Yes	No	
Suicide	Yes	No	

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY

ILLNESSES Have you ever had

PLEASE ENCIRCLE ALL ANSWERS

Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Scarlet Fever or Scarlentina	Yes	No
Diptheria	Yes	No
Smallpox	Yes	No
Pneumonia	Yes	No
Influenza	Yes	No
Pleurisy	Yes	No
Rheumatic Fever or Heart Disease	Yes	No
Arthritis or Rheumatism	Yes	No
Any Bone or Joint Disease	Yes	No
Neuritis or Neuralgia	Yes	No
Bursitis, Sciatica or Lumbago	Yes	No
Polio or Meningitis	Yes	No
Nephritis	Yes	No
Gonorrhea or Syphilis	Yes	No
Gallbaldder Disease	Yes	No
Anemia	Yes	No
Jaundice	Yes	No
Bladder Disease	Yes	No
Epilepsy	Yes	No
Migraine Headaches	Yes	No
Tuberculosis	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
High or Low Blood Pressure	Yes	No
Colitis or Other Bowel Disease	Yes	No
Hemorrhoids or any Rectal Disease	Yes	No
Nervous Breakdown	Yes	No
Food, Chemical or Drug Poisoning	Yes	No
Hayfever or Asthma	Yes	No
Hives or Eczema	Yes	No
Frequent Infections or Boils	Yes	No
Any Other Disease	Yes	No

ALLERGIES Are you allergic to

Penicillin or Sulfa	Yes	No
Aspirin, Codeine or Morphine	Yes	No
Mycins or other Antibiotics	Yes	No
Merthiolate or Mercurochrome	Yes	No
Any Other Drug	Yes	No
Any Foods	Yes	No
Adhesive Tape	Yes	No
Nail Polish or Other Cosmetics	Yes	No
Tetanus Antitoxim or Serums	Yes	No

INJURIES Have you had any

Broken or Cracked Bones	Yes	No
Sprains	Yes	No
Lacerations	Yes	No
Dislocations	Yes	No
Concussions or Head Injuries	Yes	No
Ever Been Knocked Unconscious	Yes	No

WEIGHT now _____ one year ago _____

Maximum _____ when _____

TRANSFUSIONS Have you ever had

Blood or Plasma Transfusion	Yes	No

SURGERY Have you had

Tonsillectomy	Yes	No
Appendectomy	Yes	No
Any Other Operation	Yes	No
Type _____ Year _____		
Type _____ Year _____		
Type _____ Year _____		

Have you ever been advised to have any surgical operation which has not been done _____ Yes No

Have you been hospitalized for any illness _____ Yes No

Give Details:

(* Please complete other side *)

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or Severe Headaches _____ Yes No
Fainting Spells _____ Yes No
Dissiness on change of position _____ Yes No
Unconscious Spells _____ Yes No
Blurred Vision _____ Yes No
Double vision _____ Yes No
Spots before eyes _____ Yes No
Infected Eyes _____ Yes No
Pain Behind Eyes _____ Yes No
Any changes in vision _____ Yes No
Do you wear glasses _____ Yes No
When were they last checked _____
Earaches _____ Yes No
Discharge from ears _____ Yes No
Ringing in ears _____ Yes No
Decrease in hearing _____ Yes No
Recurrent nose bleeds _____ Yes No
Recurrent head colds _____ Yes No
Sinus trouble _____ Yes No
Hay Fever _____ Yes No
Strange persistant odors _____ Yes No
Strange taste or loss in taste _____ Yes No
Persistent hoarseness _____ Yes No
Difficulty swallowing _____ Yes No
Enlarged Glands _____ Yes No
Recurrent sore throats _____ Yes No
Recurrent sores in mouth _____ Yes No
Soreness or bleeding of gums on brushing _____ Yes No
Chest pain _____ Yes No
Angina Pectoris _____ Yes No
Coughed up blood _____ Yes No
Pain in arm(s) _____ Yes No
Night Sweats _____ Yes No
Chronic or frequent cough _____ Yes No
Chronic or frequent cough on laying down _____ Yes No
Wake up night short of breath _____ Yes No
How many bed pillows do you use _____
Shortness of breath on:
Walking several blocks _____ Yes No
One flight of stairs _____ Yes No
On laying down _____ Yes No
Purple lips or fingers _____ Yes No
Palpitations or fluttering of heart _____ Yes No
High Blood Pressure _____ Yes No
Swelling of hands, feet or ankles _____ Yes No
At what time of day _____
Leg cramps on walking at night _____ Yes No
Enlarged veins in legs _____ Yes No
Recurrent stomach pains _____ Yes No
Belching or heartburn _____ Yes No
Relieved by food or medication _____ Yes No
Apetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting _____ Yes No
Vomited blood _____ Yes No
Avoid some foods _____ Yes No
What kinds _____
Avoid spices _____ Yes No
Abdominal cramping _____ Yes No
Color of bowel movement _____
Any blood in BM _____ Yes No
Rectal pain with bowel movement _____ Yes No

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Changes in size, shape or texture of BM _____ Yes No
Describe _____
Pain on urinating _____ Yes No
Difficulty in starting urination _____ Yes No
Do you get up at night to urinate _____ Yes No
How many times _____
Urinate more than before _____ Yes No
Urinate less than before _____ Yes No
Any blood in urine _____ Yes No
How many times a day do you urinate _____
Full feeling of bladder but only small amount of urine _____ Yes No

Lose urine on coughing or sneezing _____ Yes No
Discharge from penis _____ Yes No
Recurrent back pains _____ Yes No
Backaches _____ Yes No
Joint pains _____ Yes No
Swelling of any joints _____ Yes No
Redness or heat of any joint _____ Yes No
Tingling or weakness of hands or feet _____ Yes No
Muscle spasms _____ Yes No
Loss or change in sensation of hands and feet _____ Yes No
Trembling of any extremity _____ Yes No
Growth in neck or throat _____ Yes No
Hot flashes _____ Yes No
Tiredness without apparent reason _____ Yes No
Brittleness of nails _____ Yes No
Dryness of skin _____ Yes No
Easy bruising _____ Yes No
Inability to stand heat _____ Yes No
Inability to stand cold _____ Yes No
Change in hair texture _____ Yes No
Change in skin texture _____ Yes No
Any skin rash _____ Yes No
X-RAYS: Have you ever had X-rays of
Chest _____ Yes No
Stomach or colon _____ Yes No
Gallbladder _____ Yes No
Extremities _____ Yes No
Back _____ Yes No
Teeth _____ Yes No
Other _____ Yes No
EKG: Have you ever had an electrocardiogram _____ Yes No
IMMUNIZATIONS: Have you had
Smallpox vaccination within last 7 years _____ Yes No
Tetanus shots (not antitoxin which only last 2 weeks) _____ Yes No
Polio shots within last 2 years _____ Yes No

DRUGS: Laxatives never ☐ occ ☐ freq ☐ daily ☐
Vitamins never ☐ occ ☐ freq ☐ daily ☐
Sedatives never ☐ occ ☐ freq ☐ daily ☐
Tranquilizers never ☐ occ ☐ freq ☐ daily ☐
Sleeping pills,etc. never ☐ occ ☐ freq ☐ daily ☐
Aspirin, etc. never ☐ occ ☐ freq ☐ daily ☐
Cortisone Acht never ☐ occ ☐ freq ☐ daily ☐
Thyroid never ☐ yes, in past, none now ☐
daily ☐ now on _____ gr daily
Vitamins never ☐ occ ☐ freq ☐ daily ☐
Have you ever been treated for drug habits _____ Yes No
Have you ever taken Insulin or tablets for diabetes _____ Yes No
Have you ever taken Hormone tablets or injections _____ Yes No
SEX: Entirely satisfactory _____ Yes No

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset: _____
Regular?: Yes ☐ No ☐ Varies ☐
Cycle: _____ days (from start to start)
Flow: Heavy ☐ Medium ☐ Light ☐
Number of pads used per period _____
Any clots passed _____ Yes No
Pain or cramps _____ Yes No
Date of last period _____
Date of last pelvic exam _____
Date of last pap test _____
Results: Neg ☐ Pos ☐
Any discharge from vagina _____ Yes No
If so, color _____
Amount _____
Any itching of vaginal area _____ Yes No
Do you take birth control pills _____ Yes No
How long have you taken them _____
Pregnancies:
How many children born alive _____
How many still births _____
How many premature births _____
How many Cesarean Sections _____
How many miscarriages _____
Any complications with pregnancy _____ Yes No
Describe _____
Other _____

Name: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	●	●	●	●
2. Feeling down, depressed, or hopeless	●	●	●	●
3. Trouble falling or staying asleep, or sleeping too much	●	●	●	●
4. Feeling tired or having little energy	●	●	●	●
5. Poor appetite or overeating	●	●	●	●
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	●	●	●	●
7. Trouble concentrating on things, such as reading the newspaper or watching television	●	●	●	●
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	●	●	●	●
9. Thoughts that you would be better off dead or of hurting yourself in some way	●	●	●	●

=Total Score: 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

	Question	Response
1	Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐ Yes ☐ No
2	Did you have problems with depression before the age of 18?	☐ Yes ☐ No
3	Have you ever had to stop of change your antidepressant because it made you highly irritable or hyper?	☐ Yes ☐ No
4	Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐ Yes ☐ No
5	Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐ Yes ☐ No
6	Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐ Yes ☐ No

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Are you living with Adult ADHD?

The questions below can help you find out.

Many adults have been living with Adult Attention-Deficit/Hyperactivity Disorder (Adult ADHD) and don't recognize it. Why? Because its symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD – a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. **An accurate diagnosis can only be made through a clinical evaluation.** Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD, please discuss your concerns with your physician.

This Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener is intended for people aged 18 years or older.

Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener

from WHO Composite International Diagnostic Interview

Date

Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Add the number of checkmarks that appear in the darkly shaded area. Four (4) or more checkmarks indicate that your symptoms may be consistent with Adult ADHD. It may be beneficial for you to talk with your healthcare provider about an evaluation.

The 6-question Adult Self-Report Scale-Version1.1 (ASRS-V1.1) Screener is a subset of the WHO's 18-question Adult ADHD Self-Report Scale-Version1.1 (Adult ASRS-V1.1) Symptom Checklist.

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

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Name: _____ Date of birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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Name: _____ Date of birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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CONTROLLED SUBSTANCE POLICY

The use of medications classified by the Drug Enforcement Agency (DEA) as controlled substances has the potential to cause addiction and/or abuse. They are closely regulated and monitored by the authorities, and misuse by either patient or prescriber may result in serious legal consequences.

I have been informed by my prescriber and/or their staff that:

- If I drink alcohol or use street drugs while taking this medication, I risk personal injury.
- I may get addicted to this medicine, especially if I or anyone in my family has a history of drug or alcohol problems.
- If I need to stop this medicine, I must do it properly under the guidance of my prescriber or I may experience withdrawal effects.

Due to the aforementioned risk, the following agreements will apply:

- I will not share medication with family members or friends.
- I will not get controlled medications from other doctors unless it is clearly communicated to our office and the other doctor that this has been done.
- I will not use illegal drugs while taking these medications.
- I will maintain the visit schedule as per my prescriber's instructions.
- I will submit to routine urine drug screens as part of my treatment plan to assess for compliance and the presence of other medications/drugs.

Prescription & Refills

All prescriptions for controlled substances will be sent electronically directly to my pharmacy, as required by the State of Connecticut. Refill requests must be submitted at least 2 business days prior to when they will be needed in order to allow for adequate time to complete the request. Any changes to my prescription will require an office visit for thorough review with my prescriber. My prescription may not be replaced if it is lost, stolen, or used up sooner than prescribed.

Termination of Agreement

If I violate any of the above rules, or if my prescriber determines that the medication is hurting me more than helping me, the medication may be discontinued by my prescriber in a safe way. Additionally, termination from the practice may be considered following serious or repeat violations.

I have discussed this agreement with my prescriber and/or their staff, and I understand and agree to the above rules.

_____ _____

Patient's Signature Date

_____ _____

Prescriber or Designee's Signature Date