Patient Questionnaire (Male)

Name: ____ Today's Date: __________
(Last) (First) (Middle)
Date of Birth: ______________ Age: ____ Occupation: ____________________ Race: ________ Ethnicity: ________________
Home Address: ____
City: ____________________________________ State: ________ Zip: ______________
Home Phone: ____________________ Cell Phone: ____________________ Work: ____________________
Email Address: ____
How did you hear about us? ☐ Patient (Name: ____________________) ☐ Event (______________)
☐ Practitioner (Name: ____________________)
☐ Social Media (Type: ______________) ☐ Web (Keyword Searched: ______________)
☐ Signage (______________) ☐ Print (Ad seen in: ______________)

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: ____
Have you had a recent Urological Work-Up? ( ) Yes ( ) No

Do you have a family history of? ( ) Heart Disease ( ) High Blood Pressure ( )Stroke ( ) Prostate or Testicular Cancer
( ) Other Cancer_______

Personal Medical History (please check all that apply)

( ) High blood pressure
( ) High cholesterol
( ) Heart disease
( ) Stroke
( ) Heart attack
( ) Blood clot or PE

( ) Hemochromatosis
( ) Depression / anxiety
( ) Psychiatric disorder
( ) Diabetes
( ) Thyroid disease
( ) Arthritis

( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Prostate enlargement
( ) Elevated PSA
( ) Cancer:
( ) 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 my system in 12 months.

______________________ ______________________ ______________
PRINT NAME **SIGNATURE** **DATE**

AMS Checklist - BEFORE HRT

Name:______________________ **DOB:**__________ **Age:**______ **Date:**______________

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)	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14. **Decrease in beard growth**	☐	☐	☐	☐	☐
15. **Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17. **Decrease in sexual desire/libido** (lacking pleasure in sex, lack desire for sex)	☐	☐	☐	☐	☐
18. **Activity Level** (High, Med High, Med Low, Low)	H☐	MH☐	ML☐	L☐	

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. ______________________

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EVEXIAS MEDICAL DENVER/DENVER VEIN CENTER

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW CAREFULLY.

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 & Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- As required for billing insurance for services
- Comply with Law and help with public health and safety issues
- Address workers' compensation law, law enforcement, and other government requests
- Respond to lawsuits and legal actions

PHI Consent

I consent Evexias Medical/Denver Vein to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results, financial services and special offers on the following:

Phone: ________________________ Voicemail / Text (please circle all that apply)

Email: (Print please)____

I give consent to Evexias Medical Denver 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 to the following people:

Name:____Phone#:________________________

Signature

This consent will expire with the written notification to info@evexiasdenver.com

Signature:____Date_________________________

Statement of Patient Financial Responsibility

Patient Name:________________________________ **DOB:**_______

Evexias Medical Denver 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 Evexias Medical Denver, 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.

We provide paperwork for BHRT service 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.

I understand that refunds or credits are not permitted on any prescriptive medication.

I have read the above policy regarding my financial responsibility to Evexias Medical Denver 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 two times in a row without notifying Evexias Medical Denver, within 24 hours, I will have to pay a $50 non-refundable fee before scheduling for a third time.

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

Fee Acknowledgment

Although more insurance companies are reimbursing patients for Bio-Identical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your BHRT visit and procedure (see fee schedule below).

Office Visits	
New Patient Consultation Fee	$150
5-week Initial Follow up after 1st pellet insert	No Charge
Follow up Provider Visits (determined at appt)	$75-$150-$225
Labs	
Full Panel Lab Fee – Initial Visit/Annual	$250
Post-Procedure follow up Lab	$125
Thyroid Only Lab Fee	$50
Pellets	
Female Hormone Pellet Insertion Fee	$330
Male Hormone Pellet Insertion Fee	$625
Male Hormone Pellet Insertion Fee (> 2000mg)	$725

Upon request, we will give you the appropriate paperwork so you can file for reimbursement with your health insurance company.

____________________ Print Name

____________________ Signature

__________ Date

We accept the following forms of payment

*American Express, Master Card, Visa, Discover, Checks, Cash and Care Credit**