Optimal Integrative Healthcare LLC
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MALE NEW PATIENT INTAKE

Personal Data		
Name	Date	
Address	City State	Zip
Home phone	Work phone Cell phone	
Date of birth	Age	
Email		
Primary Care Physician		
Name	Phone	
Address	City State	Zip

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

Past Surgical History

Date	Surgery

Medications: Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC)

Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? _____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? _____

Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had elevated PSA? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a prostrate biopsy?		

Do you have a history of any of the following cancers:

☐ Lung ☐ Skin ☐ Other: _____
☐ Breast ☐ Lymphoma _____
☐ Colon ☐ Leukemia
☐ Prostate

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

Check which of these symptoms are troublesome and have persisted over time

☐ Low Libido
☐ Lack of Energy
☐ Decreased Strength/Energy
☐ Lost Height
☐ Decreased Enjoyment of Life
☐ Sad or Grumpy
☐ Problem with Memory/Concentration
☐ Decreased Erections
☐ Decreased Ability to Play Sports
☐ Fall Asleep After Dinner
☐ Sleep Disturbances
☐ Recent Deterioration of Work Performance
☐ Decreased Muscle Mass
☐ Hair Loss

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess		Cortisol Deficiency
☐ Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain – Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/Pains
☐ Memory Lapses	☐ Nervous	

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice has become hoarse	☐ Constipation
☐ Heart Palpitations	☐ Fatigued/Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a persistent cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema or sleep apnea?			

System Review – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition? Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Disclosure / Liability Waiver

Optimal Integrative Health – HRT Treatment

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Optimal Integrative Health, It's staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

Print Name Date

CONSENT TO TREAT & NOTICE OF OFF-LABEL USE
SAFETY OF HORMONE REPLACEMENT & OFF-LABEL DRUG USE

What is considered off-label drug/prescription use?

1. It is considered off-label use/alternative medicine if you are on any compounded form of medication. Please note that compounded medications do not meet FDA approval and therefore are considered off-label.

2. It is considered off-label use/alternative if you are on a medication which is being used outside of the medication labeling offered by the package insert. Drug labels are specific to the disease they treat and therefore if the medication is used to treat a disease that is not specified in the label, then the agent is being used off-label. Additionally, any change to the approved dose, frequency or route of administration would constitute an off-label use.

The use of off-label medications is common practice among the medical community and while we are not legally required to obtain a signed written consent it is the belief of this practice that the patient be fully aware of the current treatment plan recommended including its risks, benefits and alternatives to your plan of care. It is our belief that the treatment of hormone deficiencies can be of great benefit in improving quality of life. Medications and supplements which may be used off-label or as alternative medicine can include but are not limited to the following: Armour thyroid, estriol, estradiol, progesterone, DHEA, and/or testosterone via pellets, injections or in compounded formulations. The use of supplements may also be used in an effort to help improve conditions and or symptoms that you may have presented with during your initial consultation and throughout the course of your visit.

If you experience any side effects associated from current prescribed medications, please call the office immediately. If it is after usual business hours and you should have severe side effects, please proceed to the nearest emergency room or urgent care facility for appropriate treatment.

As a patient you have the right to refuse any off-label use of the medication being prescribed. You also have the right to ask questions regarding the current treatment plan as well as alternatives to what is being prescribed. If you have any questions or concerns please make sure to discuss with your provider during your consultation and any future visits.

MALE PATIENTS DESIRING HORMONE REPLACEMENT

The reasonable alternatives to this treatment have been explained to me and they include:

1. *Leaving the hormone levels as they are.*
2. *Treating age related diseases as they appear.*
3. *Using pharmaceutical agents that are not bio-identical in nature.*

Possible side effects for men on testosterone replacement are: acne, persistent erections, unwanted hair growth, enlargement of the prostate, enlargement of breast tissue, testicular atrophy (shrinking); and increased risk of heart attack, stroke and other cardiovascular problems.

Contraindications: Do not use hormone replacement if you have a known history of reproductive system related cancers such as prostate cancer. Exceptions include reproductive system responsive cancer which has been under remission for over 5 years.

_____(Initial) I understand the possible treatments and side effects and my responsibilities concerning hormone replacement therapy.

ALL PATIENTS: OBLIGATIONS, REPRESENTATIONS, & CONSENT

- Any questions I have regarding this treatment have been answered to my satisfaction. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent blood testing as required to monitor my hormone levels.

- I have disclosed accurate and true information regarding my medical history, medications, and surgeries.
- I certify that I am under the regular care of another physician for all other medical conditions. I will consult my primary care physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the
    - care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need.
- I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.
- I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bio-identical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.
- I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

- I also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding the outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy, hormone therapy and drugs that alter hormone levels will cease or reverse if the therapy is discontinued.
- I hereby authorize my physician to evaluate and treat the conditions I specified above. I understand that my physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I am competent to sign this Consent to Treat and have done so of my own free will.

Printed Name of Patient_____

Signature of Patient_____

Date_____