Medical History

Name:_____ Phone:_____ Date: _____

Address:_____ City: _____ State:_____ Zip: _____

DOB: _____Age: _____ Referred By: _____

Marital Status: _____ Email: _____

Allergies: _____

MEDICAL HISTORY (Please check "Yes" or "No")

YES	NO	
☐	☐	HIGH BLOOD PRESSURE (How Long?) _____
☐	☐	HEART ATTACK (WHEN?)_____
☐	☐	FAMILY HISTORY/ HEART PROBLEMS
☐	☐	PREVIOUS HEART DISEASE (PROBLEM?) _____
☐	☐	HEART CATHETERIZATION (WHEN?) _____
☐	☐	HEART FAILURE (WHEN?) _____
☐	☐	IRREGULAR PULSE
☐	☐	HEART MURMUR
☐	☐	DVT/BLOOD CLOT (WHEN?) _____
☐	☐	NOSE BLEEDS
☐	☐	STROKE
☐	☐	HIGH CHOLESTEROL
☐	☐	DIABETES (HOW LONG?) _____
☐	☐	THYROID PROBLEMS
☐	☐	GASTROINTESTINAL PROBLEMS
☐	☐	HEPATITIS
☐	☐	BLEEDING (WITH BOWEL MOVEMENTS)
☐	☐	ANEMIA
☐	☐	URINARY INFECTIONS
☐	☐	ARTHRITIS
☐	☐	SEIZURES
☐	☐	SWALLOWING PROBLEMS
☐	☐	COLONOSCOPY
☐	☐	SLEEP APNEA
☐	☐	ENLARGED PROSTATE
☐	☐	ELAVATED PSA #
☐	☐	BREAST CANCER
☐	☐	PROSTATE CANCER
☐	☐	GOUT
☐	☐	GALLBLADDER DISEASE
☐	☐	NEUROMUSCULAR/AUTOIMMUNE DISORDER (TYPE)

_____

PAST MEDICAL HISTORY

ILLNESSES:_____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

_____

_____

OPERATIONS:_____

_____

SOCIAL HISTORY

OCCUPATION:_____

INSURANCE: ☐ YES ☐ NO
☐ PPO ☐ HMO ☐ OTHER

TOBACCO USE: ☐ YES ☐ NO ☐ PAST
TYPE: ☐ CIGS ☐ CIGAR ☐ CHEWING TOBACCO
AMOUNT? _____HOW LONG?_____
WHEN DID YOU QUIT? _____

ALCOHOL USE: ☐ YES ☐ NO ☐ PAST
OF DRINKS DAILY _____WEEKLY_____MONTHLY_____
TYPE _____

CAFFEINE USE: ☐ YES ☐ NO ☐ PAST
AMOUNT DAILY _____CUPS_____CANS/BOTTLES____

PRIMARY PHYSICIAN:_____
CONTACT INFORMATION:_____

FAMILY HISTORY

FATHER: AGE:_____ DECEASED AT AGE: _____ REASON:_____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASULAR DISEASE
OTHER:_____

MOTHER: AGE:_____ DECEASED AT AGE: _____ REASON:_____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASULAR DISEASE
OTHER:_____

SIBLING: AGE:_____ DECEASED AT AGE: _____ REASON:_____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASULAR DISEASE
OTHER:_____

SIBLING: AGE:_____ DECEASED AT AGE: _____ REASON:_____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASULAR DISEASE
OTHER:_____

(PHYSICIAN USE ONLY)

PHYSICAL EXAM (IF APPRICABLE)

VITALS: BP_____ Heart Rate:_____ Weight:_____ Height:_____ BMI:_____
GENERAL _____
NECK: _____
HEART:_____
LUNGS:_____
ABDOMEN:_____
EXTREMITIES:_____
VASCULAR:_____
PROSTATE:_____

PHYSICIAN COMMENTS:_____
_____
_____
_____
_____
_____
_____
_____
_____

Notice of Privacy Practices

REBUILDING LIFE FOR MEN

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.**

RBLFM is permitted to disclose certain private health information without your consent or authorization in the following circumstances:

- Your financial information to carry out our business activities or for other legally allowed or required purposes;
- To provide you with medical treatment, services, or supplies;
- For health care operations, including, but not limited to, quality assessment and improvement activities, employee review and development activities, review and audit activities, management and general administration activities;
- To a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure;
- To provide you with recommendations for alternative treatments, therapists, health care providers or care setting;
- As required by law.

Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time. You may receive a copy of your medical records if requested in writing by you. We will also send a copy of your medical records to any third party that you designate in writing after payment of the copying fee permitted by Florida law is received.

This Notice is effective as of September 1, 2010 and may be revised without notice.

I acknowledge that I have received copies of RBLFM"S Notice of Privacy Practices, which describes how we use and disclose your health information.

_____

Patient Signature

_____

Witness Signature

No Guarantee of Services

Rebuilding Life for Men does not guarantee that any services or medications will be provided to you until you have undergone the full initial sign up process and physician's examination.

At the physician's discretion only, you will be provided medications and/or services during the course of your program at Rebuilding Life for Men.

The sign up fee is non-refundable regardless of the physician's determination on the types of services and medications that you receive during your program.

_____

Patient Signature/Date

_____

Witness Signature/Date

Terms of Service & Cancellation Policy Notice

- **Initial evaluation including comprehensive laboratory testing, and clinical assessment consultation- $500.00
    - Initial evaluation
    - Review of Medical history
    - Previous testing review if applicable
    - Patient symptoms and concerns
    - Physician evaluation and consultation
    - Review laboratory results
    - Design individual therapy
- 3 month laboratory review after initial consultation - $250.00
    - In office review (via phone if extenuating circumstances)
    - Review of laboratory results
    - Review patient's treatment and clinical response
    - Identify adjustments and additional therapies

- Bi-Annual Comprehensive evaluation laboratory and clinical assessment- $400.00
    - Comprehensive laboratory evaluation
    - In office review with physician
    - Review patient's treatment and clinical response
    - Vitals and examination as is applicable
    - Review and adjustment of individual therapy

- Prescriptions
    - Medications will be provided only at the time of consultation.
    - Prescriptions will be written for either 1 month with 2 refills or 3 months.

- Insurance
    - We do not accept or bill for any insurance.

** Only applicable at the beginning of the treatment program.

_____ _____

Client Signature Date

Credit Card Authorization

I authorize Rebuilding Life to charge the listed credit card as indicated below at the conclusion of my appointment. *We unfortunately cannot accept personal checks and apologize in advance for any inconvenience this may cause.*

By signing this authorization form I agree to pay the terms of service stated on page 5:

_____ _____

Client Signature Date

_____ _____

Name Date

_____

Signature

_____ _____

Credit Card Number Expiration Date

Billing Address:

_____

Street

_____ _____ _____

City State Zip