# **Medical History**

HEART CATHETERIZATION (WHEN?)  HEART FAILURE (WHEN?)  IRREGULAR PULSE  HEART MURMUR  DVT/BLOOD CLOT (WHEN?)  NOSE BLEEDS  STROKE  SOCIAL HISTORY  DIABETES (HOW LONG?)  DIABETES (HOW LONG?)  GASTROINTESTINAL PROBLEMS  HEPATITIS  BLEEDING (WITH BOWEL MOVEMENTS)  TOBACCO USE:   YES	name:	Pnone: Date:
Marital Status:	Address:	City: State: Zip:
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 FAILURE (WHEN?) HIGH CHOLESTEROL DIVIPLOOD CLOT (WHEN?) DIABETES (HOW LONG?) CCCUPATION: THYROID PROBLEMS HEARTIS BLEEDING (WITH BOWEL MOVEMENTS) ANEMIA HEARTIS SEIZURES SWALLOWING PROBLEMS SUMMANDAY INFECTIONS SUMMANDAY INFECTIONS ARTHRITIS SEIZURES SUMLOWING PROBLEMS COLONOSCOPY SLEEP APNEA ELANGED PROSTATE ELANGED PROSTATE ELANGED PROSTATE ELANGED PROSTATE ELANGER GALBLADDER DISEASE	DOB:Age:	Referred By:
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 FAILURE (WHEN?) HIGH CHOLESTEROL DIVIPLOOD CLOT (WHEN?) DIABETES (HOW LONG?) CCCUPATION: THYROID PROBLEMS HEARTIS BLEEDING (WITH BOWEL MOVEMENTS) ANEMIA HEARTIS SEIZURES SWALLOWING PROBLEMS SUMMANDAY INFECTIONS SUMMANDAY INFECTIONS ARTHRITIS SEIZURES SUMLOWING PROBLEMS COLONOSCOPY SLEEP APNEA ELANGED PROSTATE ELANGED PROSTATE ELANGED PROSTATE ELANGED PROSTATE ELANGER GALBLADDER DISEASE	Marital Status: E	mail:
MEDICAL HISTORY (Please check "Yes" or "No") YES NO    HIGH BLOOD PRESSURE (How Long?)   ILLNESSES:	Allergies:	
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  STROKE  HIGH CHOLESTEROL  DIABETES (HOW LONG?)  THYROID PROBLEMS  GASTROINTESTINAL PROBLEMS  HEPATITIS  BLEEDING (WITH BOWEL MOVEMENTS)  ANEMIA  ARTHRITIS  SEZURES  ARTHRITIS  SWALLOWING PROBLEMS  SWALLOWING PROBLEMS  SWALLOWING PROBLEMS  SWALLOWING PROBLEMS  SWALLOWING PROBLEMS  SWALLOWING PROBLEMS  COLONOSCOPY  TYPE  SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  PROSTATE CANCER  GALLBLADDER DISEASE		TAST MEDICAL HISTORY
FAMILY HISTORY/ HEART PROBLEMS PREVIOUS HEART DISEASE (PROBLEM?)  HEART CATHETERIZATION (WHEN?)  HEART FAILURE (WHEN?)  HEART FAILURE (WHEN?)  WHEART FAILURE (WHEN?)  HEART FAILURE (WHEN?)  WHOSE BLEEDS  STROKE  SOCIAL HISTORY  OCCUPATION:  THYROID PROBLEMS  GASTROINTESTINAL PROBLEMS  HEPAITIIS  BLEEDING (WITH BOWEL MOVEMENTS)  ANEMIA  ARTHRITIS  SEIZURES  ALCOHOL USE: YES NO PAST  ANOUNT? HOW LONG?  WHEN DID YOU QUIT?  ARTHRITIS  WHEN DID YOU QUIT?  ARTHRITIS  SEIZURES  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  ALCOHOL USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  ALCOHOL USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  AMOUNT DAILY CUPS CANS/BOTTLES  CAFFEINE USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  BREAST CANCER  PROSTATE CANCER  PRIMARY PHYSICIAN:  CONTACT INFORMATION:  CONTACT INFORMATION:	HIGH BLOOD PRESSURE (How Long?)	ILLNESSES:
PREVIOUS HEART DISEASE (PROBLEM?)  HEART CATHETERIZATION (WHEN?)  HEART FAILURE (WHEN?)  IRREGULAR PULSE  HEART MURMUR  DVT/BLOOD CLOT (WHEN?)  OPERATIONS:  STROKE  SOCIAL HISTORY  OCCUPATION:  THYROID PROBLEMS  GASTROINTESTINAL PROBLEMS  HEPAITIS  BLEEDING (WITH BOWEL MOVEMENTS)  ANEMIA  ANEMIA  AREMIA  AREMIA  ARTHRITIS  SEIZURES  ALCOHOL USE: YES NO PAST  WHEN DID YOU QUIT?  SEIZURES  ALCOHOL USE: YES NO PAST  # OF DRINKS DAILY WEEKLY MONTHLY  TYPE  SLEEP APNEA  EINARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  PROSTATE CANCER  PROSTATE CANCER  PROSTATE CANCER  PRIMARY PHYSICIAN:  CONTACT INFORMATION:	HEART ATTACK (WHEN?)	
HEART CATHETERIZATION (WHEN?)    HEART FAILURE (WHEN?)   HEART MURMUR     DVT/BLOOD CLOT (WHEN?)   OPERATIONS:   NOSE BLEEDS   NOSE BLEEDS     THYROID PROBLEMS   INSURANCE: YES NO OTHER     HEPATITIS   DATE OF DELIVERY   HOW LONG?     URINARY INFECTIONS   ARTHRITIS   ALCOHOL USE: YES NO OTHER     SEIZURES   SWALLOWING PROBLEMS   WHEN DID YOU QUIT?     SLEEP APNEA   ELAVATED PSA # BREAST CANCER   PROSTATE CANCER   PROSTATE CANCER   PROSTATE CANCER   PROSTATE CANCER   PROSTATE CANCER   PROSTATE CONTACT INFORMATION: GALLBLADDER DISEASE	FAMILY HISTORY/ HEART PROBLEMS	
HEART CATHETERIZATION (WHEN?)    HEART FAILURE (WHEN?)   IRREGULAR PULSE   HEART MURMUR   DVT/BLOOD CLOT (WHEN?)	PREVIOUS HEART DISEASE (PROBLEM?)	CURRENT MEDICATIONS:
IRREGULAR PULSE	HEART CATHETERIZATION (WHEN?)	
HEART MURMUR	HEART FAILURE (WHEN?)	
□       DVT/BLOOD CLOT (WHEN?)       OPERATIONS:         □       NOSE BLEEDS         □       STROKE         □       HIGH CHOLESTEROL         □       DIABETES (HOW LONG?)       OCCUPATION:         □       THYROID PROBLEMS       INSURANCE: □YES □ NO         □       GASTROINTESTINAL PROBLEMS       INSURANCE: □YES □ NO □ PAST         □       HEPATITIS       TOBACCO USE: □YES □ NO □ PAST         □       ANEMIA       TYPE: □CIGS □ CIGAR □ CHEWING TOBACCO         □       URINARY INFECTIONS       AMOUNT? □ HOW LONG?         □       ARTHRITIS       WHEN DID YOU QUIT?         □       SEIZURES       ALCOHOL USE: □YES □ NO □ PAST         □       SWALLOWING PROBLEMS       # OF DRINKS DAILY <u>WEEKLY MONTHLY</u> □       COLONOSCOPY       TYPE         □       SLEEP APNEA       CAFFEINE USE: □YES □ NO □ PAST         □       ELAVATED PSA #       AMOUNT DAILY <u>CUPS CANS/BOTTLES</u> □       BREAST CANCER       PRIMARY PHYSICIAN:         □       GALLBLADDER DISEASE	IRREGULAR PULSE	
NOSE BLEEDS   STROKE   SOCIAL HISTORY	HEART MURMUR	
STROKE HIGH CHOLESTEROL DIABETES (HOW LONG?) THYROID PROBLEMS GASTROINTESTINAL PROBLEMS HEPATITIS BLEEDING (WITH BOWEL MOVEMENTS) ANEMIA TYPE: CIGS CIGAR CHEWING TOBACCO AMOUNT? HOW LONG? HOW LONG TOBACTOR HOW LONG TO HOW LONG? HOW LONG TO HOW LONG TO HOW LONG? HOW LONG TO HOW LONG TO HOW LONG? HOW LONG TO HOW LONG	DVT/BLOOD CLOT (WHEN?)	OPERATIONS:
HIGH CHOLESTEROL   DIABETES (HOW LONG?)   OCCUPATION:   THYROID PROBLEMS   INSURANCE:   YES   NO   PAST   PPPO   HMO   OTHER   PPPO   HMO   OTHER   PPO   THER	NOSE BLEEDS	
HIGH CHOLESTEROL   DIABETES (HOW LONG?)   OCCUPATION:   THYROID PROBLEMS   INSURANCE:   YES   NO   OTHER	STROKE	COCIAL HICTORY
THYROID PROBLEMS  GASTROINTESTINAL PROBLEMS  HEPATITIS  BLEEDING (WITH BOWEL MOVEMENTS)  ANEMIA  TYPE: CIGS CIGAR CHEWING TOBACCO  URINARY INFECTIONS  ARTHRITIS  SEIZURES  SWALLOWING PROBLEMS  # OF DRINKS DAILY WEEKLY MONTHLY  COLONOSCOPY  TYPE  SLEEP APNEA  ENLARGED PROSTATE  ENLARGED PROSTATE  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE	HIGH CHOLESTEROL	SOCIAL HISTORY
GASTROINTESTINAL PROBLEMS    PPO	DIABETES (HOW LONG?)	OCCUPATION:
GASTROINTESTINAL PROBLEMS	THYROID PROBLEMS	
HEPATITIS   BLEEDING (WITH BOWEL MOVEMENTS)   TOBACCO USE:	GASTROINTESTINAL PROBLEMS	
ANEMIA  TYPE: CIGS CIGAR CHEWING TOBACCO  URINARY INFECTIONS  AMOUNT? HOW LONG?  ARTHRITIS  SEIZURES  SWALLOWING PROBLEMS  COLONOSCOPY  SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE	HEPATITIS HEPATITIS	□PPO □HMO □OTHER
URINARY INFECTIONS	BLEEDING (WITH BOWEL MOVEMENTS)	TOBACCO USE: ☐ YES ☐ NO ☐ PAST
ARTHRITIS  ARTHRITIS  SEIZURES  ALCOHOL USE: YES NO PAST  SWALLOWING PROBLEMS  # OF DRINKS DAILY WEEKLY MONTHLY  TYPE  SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE	ANEMIA	TYPE: $\square$ CIGS $\square$ CIGAR $\square$ CHEWING TOBACCO
SEIZURES  SEIZURES  ALCOHOL USE: YES NO PAST  SWALLOWING PROBLEMS  # OF DRINKS DAILY WEEKLY MONTHLY  TYPE  SLEEP APNEA  CAFFEINE USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE	URINARY INFECTIONS	
SWALLOWING PROBLEMS  # OF DRINKS DAILYWEEKLYMONTHLY  COLONOSCOPY  TYPE  SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE	ARTHRITIS	WHEN DID YOU QUIT?
COLONOSCOPY  SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE  TYPE  CAFFEINE USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  PRIMARY PHYSICIAN:  CONTACT INFORMATION:	SEIZURES	ALCOHOL USE: ☐ YES ☐ NO ☐ PAST
SLEEP APNEA  ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  OUT  GALLBLADDER DISEASE  CAFFEINE USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  PRIMARY PHYSICIAN:  CONTACT INFORMATION:	SWALLOWING PROBLEMS	# OF DRINKS DAILYWEEKLYMONTHLY
ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE  CAFFEINE USE: YES NO PAST  AMOUNT DAILY CUPS CANS/BOTTLES  PRIMARY PHYSICIAN:  CONTACT INFORMATION:	COLONOSCOPY	TYPE
ENLARGED PROSTATE  ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PROSTATE CANCER  GOUT  GALLBLADDER DISEASE  AMOUNT DAILY  CUPS  CANS/BOTTLES  AMOUNT DAILY  CUPS  CANS/BOTTLES  CONTACT INFORMATION:	SLEEP APNEA	CAEFEINE LICE: THE THIS TRACT
ELAVATED PSA #  BREAST CANCER  PROSTATE CANCER  PRIMARY PHYSICIAN:  CONTACT INFORMATION:  GALLBLADDER DISEASE	ENLARGED PROSTATE	
PROSTATE CANCER PRIMARY PHYSICIAN: CONTACT INFORMATION: GALLBLADDER DISEASE	ELAVATED PSA #	
GOUT CONTACT INFORMATION:  GALLBLADDER DISEASE	BREAST CANCER	
GOOT GOOT GOOT GOOT GOOT GOOT GOOT GOOT	PROSTATE CANCER	
	GOUT	CONTACT INFORMATION:
NEUROMUSCULAR/AUTOIMMUNE DISORDER (TYPE)	GALLBLADDER DISEASE	
	NEUROMUSCULAR/AUTOIMMUNE DISORDER (TYPE)	

#### **FAMILY HISTORY**

FATHER:	AGE:HISTORY OF: ☐ HEOTHER:	EART DISEASE	☐ HIGH BLO			☐ CARDIOVASULAR DISEASE
MOTHER	:: AGE: HISTORY OF: □ HE OTHER:	EART DISEASE	☐ HIGH BLO	OD PRESSURE	DIABETES	☐ CARDIOVASULAR DISEASE
SIBLING:	AGE: HISTORY OF: ☐ HE OTHER:	EART DISEASE	☐ HIGH BLO	OD PRESSURE		☐ CARDIOVASULAR DISEASE
SIBLING:	AGE:HISTORY OF: ☐ HE	EART DISEASE	$\square$ HIGH BLO	OD PRESSURE		☐ CARDIOVASULAR DISEASE
•	AN USE ONLY)					
PHYSICA	L EXAM (IF APPRICA	·			20.01	
	VITALS: BP GENERAL					_
	NECK:					
	HEART:					
	LUNGS:					
	ABDOMEN:					
	EXTREMITIES: VASCULAR:					
	PROSTATE:					
	PHYSICIAN COMME	ENTS:				

### **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.

Witness Signature

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 Noti	ce of Privacy Practices, which describes
how we use and disclose your health information.	
Patient Signature	

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### **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 t	terms of service stat	ed on page 5	:
Client Signature	Date			_
Name		Date		
Signature				VISA
Credit Card Number		Expiration Date		_
Billing Address:				
Street				
City	 State		Zip	_