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
☐	☐	ELEVATED 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:_____

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

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

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

(PHYSICIAN USE ONLY)

PHYSICAL EXAM

HEENT: _____
NECK: _____
HEART:_____
LUNGS:_____
ABDOMEN:_____
EXTREMITIES:_____
VASCULAR:_____
MEDICAL NOTES:_____
_____
_____
_____
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: _____ **Date: _____**

Witness Signature: _____ **Date: _____**

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 may be refunded, depending upon if the physician can diagnose you accordingly.

_____ _____

Patient Signature: **Date:**

_____ _____

Witness Signature: **Date:**

Terms of Service & Cancellation Policy Notice

- **Initial** evaluation including comprehensive laboratory testing, and clinical assessment consultation: $600
    1. Initial evaluation
    2. Review of Medical History
    3. Previous testing review if applicable
    4. Patient symptoms and concerns
    5. Physician evaluation and consultation
    6. Review laboratory results
    7. Design and order of individualized therapy**

- **3 month** laboratory review after initial consultation: $400
    1. In office review- over the phone if extenuating circumstances apply
    2. Review of laboratory results
    3. Review of patients' treatment and clinical response
    4. Identify adjustments and additional therapies if necessary
    5. Order revised individualized therapy**

- **Bi-Annual** Comprehensive laboratory evaluation and clinical assessment: $400
    1. Comprehensive laboratory evaluation
    2. In office review with physician
    3. Review patient's treatment and clinical response
    4. Vitals and examination as applicable
    5. Review and adjustment of the individuals' therapy
    6. Order revised individualized therapy**

- **Prescription**
    1. Dependent upon individual's designed therapy- prescriptions will be ordered on a 2 month system.
    2. Orders will last for 2 months
    3. Medication price will vary depending upon which specific medications your plan needs (i.e. peptides and/or ED drugs)
    4. Please note: This is a monthly membership to which you will be charged $200 monthly
    5. **Always expect to pay minimum $200 monthly regardless of specific medications and/or the 3 month evaluation, as well as, the bi-annual evaluations.

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

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

REBUILDING LIFE
HEALTH·WELLNESS·PERFORMANCE

CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

A few things you need to know about testosterone replacement therapy:
It is important to understand that medicine is an inexact science. Although we will carry out your treatment carefully, results can vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out right. Most of the time it will be fine; however, it is necessary to discuss potential risks, as well as the benefits expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided to you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weigh all options or consult another health care provider.

Please review the following statements which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all of your questions to your satisfaction.

Directions: Initial that you have read, understand, and agree with each statement.

_____ 1. This is my consent for Rebuilding Life for Men, including any physician, nurse, or employee who works for the company, to begin treatment for Testosterone Replacement Therapy.

_____ 2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment, such as

i. _____ Acne, breast enlargement, mood swings.
ii. _____Extra fluid in the body. This can cause problems for patients with heart, kidney, or liver disease or overweight.
iii. _____ Sleep disturbance. This is called sleep apnea. It is more likely to occur with patients who have lung disease or are overweight.
iv. _____Prostate enlargement. This may cause problems urinating.
v. _____ Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels. These will be monitored with periodic blood levels.
vi. _____Detection of subclinical and growth of prostate cancer.
vii. _____Detection of subclinical and growth of breast cancer.
viii. _____Thromboembolic event due to erythrocytosis may occur. This level will be monitored with periodic blood levels.
ix. _____Cardiovascular risk has generally not been associated with testosterone treatment. While the FDA is investigating data they have NOT concluded that testosterone therapy has increased the risk of stroke, myocardial infarction or mortality.

_____ 3. I understand that I will have periodic blood tests to monitor my blood levels.

_____ 4. I understand there is no guarantee as to the results of Testosterone Replacement Therapy. If I stop treatment, my condition may return or get worse.

_____ 5. I have had an opportunity to discuss with Rebuilding Life for Men and its medical practitioners my complete past medical and health history, including any serious problems and/or injuries. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with the answers.

_____ 6. I understand that physical exam by Rebuilding Life for Men does NOT replace a full physical exam by a personal physician.

_____ 7. I agree to have my personal physician perform a yearly full physical exam, including a digital rectal exam, lipid profile, cholesterol levels, and a comprehensive metabolic panel. If I do not have a personal physician, Rebuilding Life for Men will assist in locating one for me.

_____	_____	_____
Print Name	Signature	Date

REBUILDING LIFE
HEALTH·WELLNESS·PERFORMANCE

_____	_____
Witness	Date

Male Andropause Questionnaire

		None (1)	Mild (2)	Moderate (3)	Severe (4)	Extremely Severe (5)
1	Decline in feeling of general well-being (general state of health, subjective feeling)					
2	Joint pain and muscular ache (lower back pain, joint pain, pain in the 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 fridgety)					
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 the number of morning erections					
16	Decrease in ability/frequency to perform sexually					
17	Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for intercourse)					

Print Name: _____ Signature: _____

International Prostate Symptom Score (IPSS)

		Not at all	Less than 1 time in 5	Less than half the time	More than half the time	Almost always
						(Circle one number on each line)
1	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4
2	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4
3	Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4
4	Over the past month, how often have you found it difficult to post pone urination?	0	1	2	3	4
5	Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4
6	Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4
7	Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night to the time you got up in the morning?	0	1	2	3	4
	(0=None, 1=1 time, 2=2 times, 3=3 times, 4=4 times, 5=5times or more)					

_____ Print name

_____ Signature

Androgen Deficiency in the Aging Male Questionnaire

1	Do you have a decrease in libido (sex drive)?	Yes	No
2	Do you have a lack of energy?	Yes	No
3	Do you have a decrease in strength and/or endurance?	Yes	No
4	Have you lost height?	Yes	No
5	Have you noticed a decreased "enjoyment of life"?	Yes	No
6	Are you sad and/or grumpy?	Yes	No
7	Are your erections less strong?	Yes	No
8	Have you noticed a recent deterioration in your ability to play sports?	Yes	No
9	Are you falling asleep after dinner?	Yes	No
10	Has there been a recent deterioration in your work performance?	Yes	No

Print Name

Signature

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 based on the terms of service stated on page 5:

Client Signature: _____ Date: _____

Full Name On Card: _____ Date: _____

Credit Card Number: _____ Expiration Date: _____

CVC: _____

Signature: _____

Billing Address:

Street: _____

City:_____ State:_____ Zip:_____