NovaHealth
Natural Hormone Replacement Therapy

Patient Information-Male

Name:_____ Today's Date:_____

Date of Birth:_____ Present Weight:_____

Street Address: _____

City:_____State:_____Zip:_____

Phone-Home:_____Cell: _____

Email:_____

Patient employed by: _____

Business Address:_____

Business Phone:_____

Marital Status: (Please Circle) Married Single Divorced Widow

Spouse/Significant Other Name:_____

Spouse/Significant Other Phone:_____

In case of an emergency, whom shall we notify:_____

Phone:_____

Signature:_____Date:_____

I understand that this consultation may be recorded for training purposes only-Initial here:_____

Revised 1/2016

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Symptoms Questionnaire

Patient Name:_____ Date:_____

Please circle one of the following categories below to let us know how you are feeling at today's appointment:

Current Status- What are your CURRENT symptoms?

0 means you have **no symptoms** of this type at all / **1** means you have **very mild symptoms** of this type / **5** means you have **moderate symptoms** of this type / **10** means you have **severe symptoms** of this type.

(P)	Low_____ Moderate____ Severe___											Comments, if any
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	_____
Irritability	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety	0	1	2	3	4	5	6	7	8	9	10	_____
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Palpitations	0	1	2	3	4	5	6	7	8	9	10	_____
(E)												
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10	_____
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Loss	0	1	2	3	4	5	6	7	8	9	10	_____
(T)												
Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Weight Control	0	1	2	3	4	5	6	7	8	9	10	_____
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	_____
Erectile Dysfunction	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Body-Joint Pains	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	_____
↓ Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	_____

Patient Comments or any changes in medical conditions or medications since last report:

_____

_____

Patient Signature:_____ Date:_____

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Patient Name:_____
Date of Birth:_____

Medical History

1.	Do you have diabetes?	Yes	No
2.	Do you have hypertension?	Yes	No
3.	Do you have heart disease?	Yes	No
4.	Do you have a heart murmur?	Yes	No
5.	Do have/had kidney disease?	Yes	No
6.	Have you ever been treated for psychiatric problems?	Yes	No
7.	Have you had rheumatic fever?	Yes	No
8.	Do you have mitral valve prolapse?	Yes	No
9.	Have you ever been diagnosed with or treated for cancer?	Yes	No
10.	Have you ever had a urinary tract infection?	Yes	No
11.	Have you ever had hepatitis/liver disease?	Yes	No
12.	Have you had varicosities/phlebitis?	Yes	No
13.	Do you have a thyroid problem?	Yes	No
14.	Have you had any major accidents?	Yes	No
15.	Have you had a blood transfusion?	Yes	No
16.	Do you have asthma/lung disease?	Yes	No
17.	Do you have lupus?	Yes	No
18.	Do you have arthritis?	Yes	No
19.	Do you have any drug allergies?	Yes	No
20.	Do you have diverticulitis?	Yes	No

21. Please list all medications that you are currently taking including any Hormone Replacement Therapies:_____
_____
_____

22. Please list any medications to which you are allergic: _____
_____

23. Please list any surgeries or hospitalizations: _____
_____

24. Other medical history for yourself or family:_____
_____

Patient Initials:_____

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Medical History-continued

25. Do you have sleep disturbances?	Yes	No
26. Do you have fatigue?	Yes	No
27. Do you have depression?	Yes	No
28. Are you irritable?	Yes	No
29. Do you have anxiety?	Yes	No
30. Do you have mood swings?	Yes	No
31. Do you have weight gain?	Yes	No
32. Do you have High Cholesterol?	Yes	No
33. Do you have any hair loss?	Yes	No
34. Do you have dry skin?	Yes	No
35. Do you have no/low sex drive?	Yes	No
36. Do you have painful intercourse?	Yes	No
37. Do you have poor focus?	Yes	No
38. Do you have memory lapses?	Yes	No
39. Do you have decrease exercise tolerance?	Yes	No
40. Do you have loss of muscle tone?	Yes	No
41. Do you have night sweats?	Yes	No
42. Do you have hot flashes?	Yes	No
43. Do you have body/joint pain?	Yes	No
44. Do you have Osteoporosis?	Yes	No
45. Do you have Fibromyalgia?	Yes	No
46. Do you have Chronic Fatigue Syndrome?	Yes	No
47. Do you have Restless Leg Syndrome?	Yes	No
48. Do you get migraine headaches?	Yes	No
49. Do you have or get Palpitations?	Yes	No
50. Do you have Diabetes?	Yes	No
51. Do you have High Blood Pressure?	Yes	No
52. Do you have Heart Disease?	Yes	No

53. Do you smoke cigarettes:_____ If yes, # per day:_____ How many years?_____

Patient Initials:_____

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Date of Birth:_____

Informed Consent

I,_____, acknowledge that I have been presented with a copy of the Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorizations before any other disclosures may be made.

Initial:_____ Date:_____

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself, to notify me of my appointment or to tell me the test results are back. We will not lease a test results on your answering machine.

Patient Signature:_____
Date:_____

I request that my protected health information be disclosed to the following persons or facility as listed below:_____
_____
_____
_____

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Notice of Privacy Practices

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agency authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by State and Federal Law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

More Stringent Laws

We will evaluate whether your protected health information is governed by more stringent laws or regulations prior to our use or disclosure. There are other more stringent laws and rules, such as the federal substance abuse confidentiality regulations, the State Medical Health confidentiality statue(s), the State Public Health confidentiality provisions, and State Minor Consent statue(s), governing status (i.e., emancipation, marital status, etc.) or type of treatment (abortion, sexually transmitted disease, birth control, etc.), that may affect how we handle your information.

_____ _____

Signature of Patient (or Legal Representative) Date