Neighborhood Wellness Clinic

Look Good. Feel Great. Live Better.

Patient Questionnaire (Male)

Name: _____ Today's Date:_____

(Last) *(First)* *(Middle)*

Date of Birth: _____ Age:_____ Occupation:_____

Home Address:_____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? _____

In Case of Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Pharmacy Name:_____ Phone:_____

Address:_____

Primary Care Physician's Name:_____ Phone:_____

Address:_____

May we share your clinical information with your PCP? ☐ Yes ☐ No

CONSENT TO COMMUNICATE

☐ Yes ☐ No	Call Home Phone ☐Yes ☐ No	OK to leave voicemail	☐ Yes ☐ No	OK to leave message with a 3rd party?	
☐ Yes ☐ No	Call Cell Phone ☐ Yes ☐ No	OK to leave voicemail	☐ Yes ☐ No	OK to leave message with a 3rd party?	
☐ Yes ☐ No	Call Work Phone ☐ Yes ☐ No	OK to leave voicemail	☐ Yes ☐ No	OK to leave message with a 3rd party?	
☐ Yes ☐ No	Send Email ☐ Yes ☐ No	Appointment reminders	☐ Yes ☐ No	Office Specials	
☐ Yes ☐ No	Send Text ☐ Yes ☐ No	Appointment reminders	☐ Yes ☐ No	Office Specials	
☐ Yes ☐ No	Send Regular Mail ☐ Yes ☐ No	Appointment reminders	☐ Yes ☐ No	Office Specials	

If consent is given for a 3rd party to receive a message, please list their information below.

Name: _____ Relationship: _____ DOB_____ Ok to Release Results: ☐ Yes ☐ No

Name: _____ Relationship: _____ DOB_____ Ok to Release Results: ☐ Yes ☐ No

NO SHOW POLICY

This notice is to inform our patients that we have a no- show/cancellation policy. One of the great things about our office is that when you schedule an appointment, we hold that time specifically for you! If you need to reschedule or cancel an appointment, it needs to be done at least 24 hours in advance of your appointment time. Any "no shows" or cancellations made outside of the 24-hour courtesy, a nonrefundable $40 fee will be charged to your account. We generally provide a complimentary reminder 24 hours prior to your appointment; if you call before or after the business hours of 8am-5pm M-F, please leave a detailed voicemail. By signing below, you consent to our "No Show Policy."

<u>Card Information:</u>

Card Type: _____

Card Number: _____

Expiration: _____

Security PIN: _____

Zip Code: _____

Authorization Signature: _____ Date: _____

MEDICAL HISTORY

Height: _____ Weight: _____

Have you ever had any issues with local anesthetic? ☐Yes ☐ No If yes please explain: _____

Have you ever had a serious head injury? ☐Yes ☐ No If yes please explain: _____

Are you on a special diet? ☐Yes ☐ No If yes please explain: _____

Any known drug allergies: ☐Yes ☐ No If yes please explain:

Do you smoke or vape? ☐Yes ☐ Never ☐ Quit How much? How often?_____Age started?

Do you drink alcohol? ☐Yes ☐ Never ☐ Quit How much? How often?_____Age started?

Use of drugs or marijuana? ☐Yes ☐ Never ☐ Quit How much? How often?_____Age started?

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin _____

Supplements: Past HRT: _____

_____

Current Hormone Replacement Therapy: _____

_____ Surgeries, list all and when:

_____

Other Pertinent Information: _____

Do you have a personal history of?

☐ Asthma
☐ COPD
☐ Kidney disease
☐ Kidney stones
☐ Problem scarring
☐ Hypertension (High BP)
☐ High cholesterol
☐ Heart rhythm problems
☐ Stroke
☐ Heart attack
☐ Blood clot or pulmonary emboli
☐ Hemochromatosis (Iron overload)
☐ Seizures
☐ Depression / anxiety
☐ Sleep apnea: Use CPAP ☐Yes ☐ No
☐ Psychiatric disorder
☐ Diabetes
☐ Thyroid disease (Nodule/Goiter)
☐ Hyperthyroidism (High Thyroid Function)
☐ Hypothyroidism (Low Thyroid Function)
☐ Arthritis
☐ Migraines
☐ Trouble passing urine or take Flomax or Avodart
☐ Chronic liver disease (hepatitis, cirrhosis)
☐ Fatty liver disease
☐ Prostate enlargement
☐ Elevated PSA
☐ Autoimmune disease
_____
☐ Cancer:_____
☐ Testicular or prostate problems?
Year: _____
☐ Other:
Year: _____

Do you have a family history of?

☐ Heart Disease
☐ Chronic Lung Disease
☐ Bleeding Tendency
☐ Tuberculosis
☐ Thyroid Trouble
☐ Blood Clotting Disorder
☐ Obesity
☐ Asthma
☐ Autoimmune Disease:

☐ Mental Illness
☐ Leukemia
☐ Seizures
☐ Allergies
☐ Migraine Headache
☐ Cancer
☐ Gout

☐ Kidney Disease
☐ Heart Disease
☐ Diabetes
☐ Arthritis
☐ High Blood Pressure
☐ Prostate Cancer
☐ Other: _____

ADVANCED PRACTICE REGISTERED NURSE/ PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

1551 N. Walnut Ave, Suite 42 New Braunfels, TX 78130

Phone: 830.387.4400 Fax: 830.387.4273

6051 FM 3009 Suit 255 Schertz, TX 78154

Phone: 210.651.1744 Fax: 210.651.1746

Neighborhood Wellness Clinic has on staff Advanced Practice Registered Nurse/ and/ or Physician Assistant to aid in the treatment of our patients. Advanced Practice Registered Nurses (APRN) or Physician Assistants (PA) are not physicians. An Advanced Practice Registered Nurse is a Registered Nurse who has received advance education and training in the provision of healthcare services. A Physician Assistant is an individual trained in Physician Assistant studies and has received advanced education and training in the provision of healthcare services. The APRN/PA can evaluate, diagnose, monitor, and treat common acute and chronic disease. as well as provide healthcare maintenance. In addition, the APRN/PA may also treat minor lacerations and other minor injuries.

I (patient name or legal guardian), _____, have read the above, and hereby consent to the services of an Advanced Practice Registered Nurse (APRN)/ Physician Assistant (PA) for my (or legal dependent's) health care needs.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form Is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the

patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health Insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which Identifies a patient's condition or information which is not already a matter of public record, the normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It Is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, 6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

By signing below, I acknowledge the above consents and policies.

Signature: _____ Date: _____

Erythrocytosis

A side effect of continuous testosterone injections is, erythrocytosis; this condition is the increase of red blood cells (RBCs) in the body. There are several reasons this can happen: testosterone therapy, heavy smoking, sleep apnea, extreme protein diets (red meat), dehydration, living at high altitude, certain blood disorders/cancers. Since male testosterone therapy is on the rise, extra attention is given to the amount of red blood cells within the body. Men who take a higher dose of testosterone tend to have a rise in their hematocrit levels. Elevated red blood cells are reflected on a complete blood count (CBC) test as increased red blood cell count, hemoglobin, and/or hematocrit.

We will be taking your blood every 6 months to evaluate your counts. Anyone with extremely high hematocrit levels may need to have their dosages reduced. As there are other causes of erythrocytosis, more evaluation may be necessary, or lifestyle modification (i.e., smoking cessation, treatment for sleep apnea) may need to occur.

Therapeutic phlebotomy is one way to decrease counts although it is not routinely recommended. Phlebotomy will reduce hematocrit by about 3%. However, the body's response to this loss of blood is to increase blood counts in compensation. A typical blood draw is usually one pint of whole blood and take between 30-40 minutes to complete. Another option is a platelet donation; it is a more extensive blood draw that requires more time, but it can lower hematocrit levels by up to 15%. Regular blood donation can also contribute to iron deficiency, with can cause fatigue.

Usually hematocrit levels will normalize in about 6 months of therapy, but this is not always the case. Some doctors recommend the use of baby aspirin (81mg) every day. However, this is really only beneficial if you have other risk factors for blood clotting (i.e., smoking/tobacco use, uncontrolled high blood pressure or sleep apnea, or personal or family history of blood clots).

Fertility

I understand that by using testosterone replacement, my sperm count will naturally decrease. This is not permanent, but takes 6-12 months to recover. There are medications that can help recover fertility quicker.

Testicular Atrophy

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement, I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.

HCG

Human Chorionic Gonadotropin, also known as HCG, is a natural hormone produced by an embryo once it is implanted into the Mother's uterus. While HCG is primarily used as a fertility treatment in both men and women, HCG has also been found to be a strong tool in weight loss. With this in mind, it is important for women to use a form of contraception before or right after an activity. It is not uncommon to experience some spotting or fluctuation between periods. The hormone will not make you lose weight by itself, but in conjunction with a strict diet and exercise, the hormone will change how you lose weight. HCG helps target abnormal body fat, especially in the stomach area.

Since HCG is a hormone, communication is extremely important.

You should inform your doctor if you're pregnant or trying to become pregnant. If you're pregnant and continue to take the HCG injections, it can cause birth defects. It is also important to discuss any past or current cancer diagnosis, especially any cancers that are stimulated by hormones, such as cervical or prostate. If you've been diagnosed with any fibrosis problems or polycystic ovary syndrome, it's critical to tell the doctor overlooking your program.

The HCG diet is under the safe and constant supervision of a physician.

Lipotropic

Methionine:	This is an amino acid which speeds up the removal of fat from the liver and prevents excess fat buildup in the body. It is great antioxidant and it fights free radicals.
Inositol:	This aids in weight loss and the redistribution of body fat by breaking down or emulsifying fats in the body. It also helps to prevent high cholesterol and atherosclerosis.
Choline:	This assists in the emulsification of fats and cholesterol by helping form smaller fat globules in the blood and aiding the transport of fats through smaller vasculature out of the cells.

- What is the role of lipotropes?

Lipotropic compounds such as methionine, inositol, and choline help catalyze the breakdown of fat in the body. They promote the removal of fat from the liver and are necessary to maintain a healthy liver. The fat that is removed and then burned for additional energy. If adequate lipotropes are not present, bile and fats may become trapped in the liver which results in cirrhosis and a reduced fat metabolism.

- What is the role of B vitamins?

The B vitamins help increase metabolism, enhance immune functioning, and promote cell growth. They are water soluble and should be replenished often due to excess being excreted in the urine. The B12 in the injections is in its methylated form and is known as methylcobalamin; it is the most biologically active form of B12, and the only form that can cross the blood-brain barrier.

- How often should I get a shot?

It is recommended that patients receive an injection twice a week. This is because the lipotropes only last in the body for 3 to 4 days. We do not recommend coming into the clinic to receive both shots within a 24-hour period since excess is excreted in the urine.

The complex of B vitamins included in the lipotropic injection:

Vitamin B1 (thiamine)
Vitamin B2 (riboflavin)
Vitamin B12 (methylcobalamin)
Vitamin B5 (pantothenic acid)
VitaminB6 (pyridoxine/pyridoxal/pyridoxamine)
Vitamin B7 (biotin)
Vitamin B9 (folic acid)
Vitamin B3 (niacin/niacinamide)

By singing below, I am acknowledging that I have read and received NWC's article on Polycythemia (high hemoglobin and hematocrit). Any questions I may have will be answered by the staff or management. I agree to abide by the clinic's rules on blood testing and/or blood donations and therapeutic draws. By signing below, you are stating that you have read the information above and are informed of the risks associated with Testosterone, HCG, and Lipotropic injections.

Printed Name: ____

Signature: ____