Men's Health Patient Registration

Date_____

Last Name_____First name_____Middle Initial_____

Street Address_____

City/State/Zip_____

Home Phone_____Cell _____Email_____

Date of Birth ___/____/_____Age_____S.S.#_____Height_____Weight_____

Primary Physician_____Urologist_____Cardiologist_____

Employment_____Work Address_____

Preference of notifications/reminders: (circle) Text Email Cell

Emergency contact

Name_____Relationship_____

Phone_____

Pharmacy Information

Pharmacy_____Address_____Phone_____

Past Medical History

_____

_____

_____

_____

Medications Dose Frequency

_____

_____

_____

_____

_____

Surgeries/Hospitalizations/Major illness Year Reason

_____

_____

_____

Occupation_____Work Activity Level: (circle) Sedentary Active

Shift/Weekly work hours_____

Marital Status: (circle) single married divorced

Physical Activity

Type_____Frequency/Duration/week_____

Intensity:(circle) Low Medium High

Sleep

Ave. hours/night_____Wakeups per night/Reason_____

Tobacco use

Cigarettes Chewing tobacco cigars

Duration (years)_____Frequency (per week/packs)_____

Alcohol use Yes No type_____ Duration (years)_____ Frequency_____

Prior Hormone Replacement Therapy

Have you had testosterone replacement?

□ Yes

□ No

Date of treatment_____

Prior Testosterone Replacement Therapy type_____

Office Financial Policy

- All payments are due at the time of service. Payments are to be paid in the form of cash, debit, or accepted credit cards. We do not accept insurance but will provide documentation with diagnostic codes for you to submit to your insurer.
- You must notify our staff of appointment cancellation at least 24 hours in advance or you will be charged the cost of a full visit.
- You can use insurance for lab and prescriptions, although coverage varies based on your policy.

I have read and understand all of the above and have agreed to these statements.

Privacy Notice: I have read and understand Egea Medical's privacy policy.

Signature_____Date_____

Informed Consent for Testosterone Replacement Therapy

The following information will assist you in making an informed decision regarding the use of testosterone therapy. Many of these side effects are rare however have been reported with testosterone use. Please review this information and sign if you agree and understand.

Some known or suspected risks of testosterone therapy include but are not limited to:

- Elevated hematocrit (red blood cell concentration in blood)
- Increased risk of blood clots
- Elevated blood pressure
- Lowered sperm production
- Breast tissue growth (gynecomastia)
- Worsening sleep apnea
- Acne
- Hair loss
- Reduced testicular size
- Prostate cancer progression
- Breast cancer progression
- Elevation in liver function tests
- Possible interaction with medications
- Changes in urinary habits

Testosterone therapy requires close medical monitoring and regular office visits. I agree to be compliant with all scheduled office visits as well as lab testing. I also agree to follow all instructions by the doctor regarding medication doses and timing of administration. I agree not to obtain or take any other hormone therapy or divert medications. I understand that I will not receive any medications or prescriptions if I fail to be compliant with the scheduled program. I certify that I have received and understand I have the right to refuse or discontinue therapy at any time.

Patient name_____

Signature_____Date_____