New Patient Package

Please take time to read this carefully and answer all the questions as completely as possible.
We look forward to partnering with you to help you feel your best again.
Please bring this completed form to your initial appointment.

Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social Security Number: _____ E-Mail Address:_____

May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

May we contact your Physician regarding your treatment at Men's Wellness Centers? ( ) YES ( ) NO

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widower ( ) Living with Partner ( ) Single

Treatment Interested in (check all that apply):

( ) Total Hormone Replacement Therapy
( ) Testosterone Replacement Therapy
( ) Erectile Dysfunction
( ) Weight Loss
( ) Energy Boost

Medical History

Any known drug allergies: _____

Medications Currently Taking: _____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

_____

Other Pertinent Information: _____

Medical Illnesses/ Conditions:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Polycythemia.
( ) Cancer (type): _____
Year: _____
( ) Sleep Apnea.
( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Sickle Cell.
( ) Priapism.
( ) Peyronie's Disease.
( ) Anxiety.

Comments / Other Medical Conditions:

_____

_____

_____

_____

General Wellness Overview:

Symptoms ***(please check yes or no)***

	Yes	No
Decline in general well being		
Exhaustion/lacking vitality		
Decreased desire/libido		
Decreased morning erections		
Inability to obtain an erection		
Inability to maintain an erection		
Use of ED meds		
Ineffectiveness of ED meds		
Breast Development		
Poor sleep		
Daytime fatigue/Low energy		
Decreased motivation		
Anxiety/Irritability/ Depression		
Decreased muscle mass/ Strength		
Decreased endurance		
Weight gain		
Inability to lose weight		
Healthy diet		
Regular exercise		

Print Name **Signature** **Today's Date**

MEN'S WELLNESS CENTERS
NOTICE OF PRIVACY PRACTICE ABSTRACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INOFRMAION.
PLEASE REVIEW IT CAREFULLY.

This notice is effective **June 15, 2015**
Protected heath information is information that identifies you as the patient. It has been collected from you or has been created or received by a health care provider (to include all MWC staff), a health plan, your employer, or a healthcare clearinghouse. It relates to your physical or mental condition and is used in providing health care to you.

Men's Wellness Centers responsibilities to you include the implementation of policies and procedures to ensure your health information remains private. Men's Wellness Centers must:

- Protect the privacy of the protected heath information that it has or keeps about you.
- Provide you with this notice, which delineates how we collect and maintain protected health information about you.

Men's Wellness Centers will not use or give out your information without your authorization, except as described in this notice. Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. This information includes your symptoms, exam and test results, diagnoses treatment and a plan for future care or treatment. This information serves as a:

- Basis for authorizing payment for your care
- Source of information that may be used to pay claims for your care
- Legal proof of the care you receive
- Means for you or others to verify that the service billed were received
- Source data for medical research, in certain circumstances
- Source of information for public heath offices who work to help improve the health of the state or nation.
- Source of data for quality management, disease management, health promotion, and marketing

What should you do if you have a complaint about the way your health information is handled by Men's Wellness Centers?

If you believe that your privacy rights have been violated, you may file a complaint with Men's Wellness Centers, or with the Secretary of Heath and Human Services.

To file a complaint with Men's Wellness Centers or to appeal a decision about your health information, send your request in writing to Men's Wellness Centers Practice Manager. The address and phone number are located at the end of this notice.

To file a complaint with the Secretary of Health and Human Services, send your request in writing to:

The Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

You will not lose your Men's Wellness Centers care benefits if you file a complaint. You will still receive treatment from Men's Wellness Centers as long as you are a patient.

Please send questions or requests to the following address:

Men's Wellness Centers
827 Diligence Drive, Suite 206
Newport News, VA 23606
(757) 806-6263

Acknowledged:

_____ _____
Signature Date

men's WELLNESS CENTERS