



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: _____

How may we contact you in the future? Email Text Mobile Home Phone

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 w/ 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: _____

- | | |
|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Testicular or Prostate Cancer |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Elevated PSA |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Trouble Passing Urine or Take Flomax or Avodart |
| <input type="checkbox"/> Blood Clot and/or Pulmonary Embolism | <input type="checkbox"/> Chronic Liver Disease (hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Polycythemia | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Priapism | <input type="checkbox"/> Peyronie's Disease |
| <input type="checkbox"/> Cancer (type) _____ Year: _____ | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Family medical history: _____ | |

Comments / Other Medical Conditions:



General Wellness Overview: (Check what applies to you)

PHYSICAL

- | | |
|---|--|
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Delayed Recovery from Workouts |
| <input type="checkbox"/> Breast Development | <input type="checkbox"/> Failure to Progress in Workouts |
| <input type="checkbox"/> Inability to Lose Weight | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Decreased Strength | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Decreased Endurance | <input type="checkbox"/> Other _____ |

PSYCHOLOGIC

- | | |
|---|---|
| <input type="checkbox"/> Decreased Motivation | <input type="checkbox"/> Decreased Mental Clarity / Focus |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Other _____ | |

SEXUAL

- | | |
|--|---|
| <input type="checkbox"/> Decreased or No Morning Erections | <input type="checkbox"/> Ineffective Use of ED Medication |
| <input type="checkbox"/> Inability to Obtain Erection | <input type="checkbox"/> Use of Medication (Viagra or Cialis) |
| <input type="checkbox"/> Inability to Maintain Erection | <input type="checkbox"/> Premature Ejaculation (PE) |
| <input type="checkbox"/> Decreased Turgor or Rigidity | <input type="checkbox"/> Other _____ |

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 INFORMATION.
PLEASE REVIEW CAREFULLY.**

This notice is effective **June 15, 2015**

Protected health 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 health 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 health 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 Health 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 if 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: _____