BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

MALE PATIENT INFORMATION FORM

Last Name_____ First Name _____Middle_____

Date of Birth _____/_____/_____ Age_____ Sex: M / F Marital Status: M S D W

Email: _____ Cell Phone: _____

Home Address: _____

City_____ State _____ Zip_____

Employer_____Occupation_____

REASON FOR VISIT / MAIN CONCERN_____

Primary Care Physician_____ Date of Last Physical_____

PRESCRIPTION MEDICATIONS *(PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)*

Medication	**Dose and Frequency**
1.	
2.	
3.	
4.	
5.	
Additional:	

NON PRESCRIPTION MEDICATIONS *(LIST OVER THE COUNTER, HERBAL, AND VITAMINS)*

1.	3.	5.
2.	4.	6.

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS? NO_____YES_____

MED:_____ REACTION:_____

MED:_____ REACTION:_____

PLEASE LIST ANY ALLERGIES OR REACTIONS TO FOODS OR ENVIRONMENTAL SUBSTANCES?

_____

Health History For Men

Lifestyle information: Answer the following questions with Yes or No and explain if necessary.

Are you concerned about aging? ☐Yes ☐No, Do you have a specific concern?_____

Are you concerned about memory loss? ☐Yes ☐No

Are you under a great deal of stress, now or recently? ☐Yes ☐No

Are you concerned about your weight? ☐Yes ☐No

Current Symptoms: Please mark any of the following that may apply.

☐Fatigue or lack of energy
☐Dry and/or wrinkled skin
☐Insomnia
☐Change in mood, Anxiety/depression
☐Decreased or absent sex drive (libido)
☐Loss of spontaneous morning erections
☐Infrequent or absent ejaculations
☐Shrinking testicles
☐Erectile issues
☐Breast development
☐Declining mental ability and memory
☐No result from erectile dysfunction medications
☐Diminished strength and exercise tolerance
☐Muscle shrinkage
☐Joint ache/new onset of arthritic symptoms
☐Weight gain, belly fat
☐Hair loss
☐New headaches
☐Mental sluggishness and difficulty focusing
☐ Feeling of hopelessness or no motivation
☐Cold all the time
☐Swelling
☐Poor balance and coordination
☐ Brittle nails
☐Constipation
☐Height decreased, Osteoporosis or Osteopenia
☐Other _____

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

Personal Medical History: Please mark any of the following that may apply.

☐Any form of Hepatitis or HIV- Type_____

☐Prostate cancer

☐Colon cancer

☐Other cancer _____

☐Narcolepsy

☐Blood clot or clotting disorder

☐Heart attack

☐Stroke

☐Heart bypass

☐Vascular disease

☐High blood pressure

☐High cholesterol

☐Heart arrhythmia

☐Emphysema (COPD)

☐Tuberculosis

☐Glaucoma

☐ADD/ADHD

☐Depression/anxiety

☐Manic depression

☐Schizophrenia

☐Kidney disease

☐Seizures

☐Irritable Bowel Type Symptoms

☐Psychological/psychiatric illness_____

☐Restless leg

☐Sleep apnea

☐Prostate enlargement

☐Arthritis

☐Rheumatoid arthritis

☐Fibromyalgia

☐Lupus or autoimmune disease

☐Urinary Symptoms

☐Chronic fatigue

☐Adrenal fatigue

☐Multiple sclerosis

☐Diabetes type 1

☐Diabetes type 2

☐Hypoglycemia

☐Insulin resistance

☐Thyroid disease Hypo_____ Hyper_____

☐Addisons disease or cushings disease

☐Liver disease

☐Glaucoma

☐ GI Upset/GERD

☐Other _____

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

Surgical History: Please list all surgeries and approximate dates.

_____

_____

_____

_____

Social History: Please mark any of the following that may apply.

☐I have completed my family ☐I am married

☐I have a partner ☐I am in a committed relationship

☐I am sexually active ☐I want to be sexually active

Habits: Please mark any of the following that may apply.

Smoking:

☐Never Smoked

☐I smoke cigarettes: packs per day:_____

☐I smoked previously. Quit Date: _____

☐ I use vapor cigarettes

Drinking:

☐ I don't drink , but not due to problem with alcohol

☐I drink more than 12 drinks per week

☐ I drink less than 12 drinks per week

☐ I am a recovering alcoholic

Caffeine:

☐I drink caffeinated beverages. _____servings/day. Type: _____

Other Drugs:

☐I use or have used marijuana in the last year

☐I use cocaine or Heroin or have a history with the use of them.

☐ I use other drugs: _____

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

Exercise History: Please mark any of the following that may apply

☐I don't exercise

☐I exercise _____ days /week, for _____ minutes/day

☐Type of exercise that you do regularly: _____

Dieting: Please mark any of the following that may apply.

Do you overeat? ☐Yes ☐No, How is your appetite?_____

Do you ever have any reactions to food? ☐Yes ☐No _____

Do you crave sweets? ☐Yes ☐No, Or any other food cravings?_____

Please mark which of the following describes your typical daily diet:

☐I eat anything I want

☐I limit carbohydrates

☐I don't eat much but gain weight anyway

☐I eat a low fat diet

☐Vegan/vegetarian

☐I eat a balanced diet, 3 times a day

☐Special diet or restrictions _____

☐Other _____

Preventive Medical Care: Please list the date that corresponds with the exam.

☐Physical exam Date _____

☐Labs _____

☐Prostate exam Date _____

☐PSA test Date _____

☐Bone Density Date _____

☐Colonoscopy Date _____

Polyps? ☐Yes ☐No

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

Family History (Grandparents/mother/father/sister/brother): Please mark any of the following that may apply.

☐Heart disease
☐Alzheimer's/dementia of any type
☐Colon cancer
☐Prostate cancer
☐Breast cancer
☐Blood clots/Bleeding Disorders
☐Uterine cancer
☐Rheumatoid arthritis/Lupus
☐Other Cancer: _____
☐ Other Autoimmune Disease
☐Stroke
☐Thyroid disease- high or low
☐Arrhythmia
☐Osteoporosis
☐Diabetes
☐Hemochromatosis
☐Any other pertinent family history _____

Anti-Aging/Hormone Consultation Patients: Please mark any of the following that may apply.

Sexual History (present): Please mark any of the following that may apply.

☐My sex life is good
☐I have issues with the ability to ejaculate
☐My sex life has gotten worse

Hormone Replacements I have used in the past: Please mark any of the following that may apply.

☐Pellets
☐Patches
☐Gel/creams applied on the skin
☐Injectables
☐Other_____

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY MEDICAL CARE AND I, THEREFORE CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM DR. OHMS OF ANY CHANGES OR UPDATES.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT BALANCED REJUVENATION HAS NO CONTRACTS WITH MEDICARE AND/OR ANY OTHER INSURANCE COMPANY. THEREFORE, BALANCED REJUVENATION IS NOT OBLIGATED TO PRE-CERTIFY TREATMENT, PROCESS PRIOR AUTHORIZATIONS OR ANSWER LETTERS OF APPEAL.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

*(at times, we may need to send appointment reminders, notices of office closures, whole practice updates, etc. If there is a reason that you ABSOLUTELY do NOT want us to use a certain method of communication, please state it here and/or tell us verbally at this appointment. _____

Is it ok to leave a message that includes:

Practice name and phone number only? _____Yes _____No

Detailed or specific message? _____Yes _____No

Would you like to authorize someone else to schedule, confirm, or change appointments? _____Yes _____No

If so, please provide: Name _____ Phone _____

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name _____

HOW DID YOU HEAR ABOUT US?

___ Friend or Family Member (Name) _____

___ Website: ___ *BalancedRejuvenationMed.com*

___ Internet Search (Google / Yahoo / Other) _____

___ Other _____

Deanna Ohms, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on her website www.balancedrejuvenationmed.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

Name:_____ Signature:_____ _____ Date:_____