Wellspring Restorative Health

Phone: 480.861.3916 ◆ **Fax**: 602.910.5504

MALE PATIENT INFORMATION

Name _____ Today's Date _____
Last First Middle

Date of Birth _____ SSN# _____

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Mobile Phone _____

Email to receive appointment reminders_____

In the event we are unable to contact you by the means you've provided above, we'd like to have the ability to contract you through your spouse. Please provide the necessary information about your spouse/partner below;

Spouse/Partner _____
Last First Middle

Spouse/Partner DOB _____

Spouse/Partner's Telephone (mobile preferred) _____

In case of emergency, whom should we notify?

_____

Contact Number(s) _____/_____
Home Number Mobile Number

Relationship _____

Your Signature_____

PAST MEDICAL HISTORY

Do you have/had hypertension? Y ☐ N ☐
Do you have heart disease? Y ☐ N ☐
Do you have mitral valve prolapse? Y ☐ N ☐
Do you have a heart murmur? Y ☐ N ☐
Have you ever been anemic? Y ☐ N ☐
Have you ever had hepatitis/liver disease? Y ☐ N ☐
Have you ever had rheumatic fever? Y ☐ N ☐
Have you ever been anemic? Y ☐ N ☐
Have you ever had thyroid problems? Y ☐ N ☐
Do you have arthritis? Y ☐ N ☐
Do you have/had kidney disease? Y ☐ N ☐
Have you had any bladder or kidney problems? Y ☐ N ☐
Do you have diabetes? Y ☑ N ☐
Have you ever been treated for any psychiatric problems? Y ☐ N ☐
Do you have any drug allergies? Y ☐ N ☐
Have you had your cholesterol checked? Y ☐ N ☐ Was it normal? Y ☐ N ☐
Please list: _____

_____

Have you had any local anesthesia complications? (at the dentist, etc) Y ☐ N ☐
Please Describe : _____

_____

Do you have a primary care or family doctor? Y ☐ N ☐
Please list name, phone, address (as much as possible) _____

_____

Please list any surgeries and/or hospitalizations:

_____

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of:

Hypertension (high blood pressure)? Y ☐ N ☐ Family Members (Please name relation)

_____

Heart Disease? Y ☐ N ☐ Family Members (Please name relation) _____

_____

뺘먓 떎 Disease? Y ☐ N ☐ Family Members (Please name relation) _____

_____

Colon Cancer? Y ☐ N ☐ Family Members (Please name relation) _____

_____

Diabetes? Y ☐ N ☐ Family Members (Please name relation) _____

_____

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SOCIAL HISTORY

Do you smoke? Y ☐ N ☐ How much: _____ How many yrs: _____
Do you have any drug allergies? Y ☐ N ☐ Are you currently taking any medications? Y ☐ N ☐
If so please list: _____
_____
Please list all MAJOR surgeries (include year and reason) _____
_____ _____
_____
_____
Do you drink alcohol? Y ☐ N ☐ What type(s): _____
_____
How many drinks per week, on average, do you drink? _____ Are you CURRENTLY using any form of hormone? Y ☐ N ☐ Type: Estrogen (estradiol ☐ estriol ☐ estrone ☑)
Testosterone ☐ DHEA ☐ Progesterone ☑
Other _____
Please state the dose (if possible) _____ form: cream ☐ lozenge ☐ oral (capsule) ☐
shot ☐ pellet ☐ patch ☑ other: _____
Have you PREVIOUSLY been on any form of HARMONE in the past? Y ☐ N ☐
Please describe (which hormones, what form, what dose, when and for how long _____
_____
_____
Are you currently sexually active? Y ☐ N ☑
Do you have a history of Sexually Transmitted Diseases? Y ☐ N ☑
Have you had a sperm count? Y ☐ N ☐
Have you had the mumps? Y ☐ N ☐
Have you had Testicular Cancer? Y ☐ N ☐
Do you have Prostate problems? Y ☐ N ☐
If yes, please describe: _____
_____
Do you experience any of the following:
Fatigue Y ☐ N ☐
Decrease in memory Y ☐ N ☐
Decreased sexual drive Y ☐ N ☐
Decrease in exercise response Y ☐ N ☐
Poor recovery from exercise Y ☐ N ☐
Anxiety Y ☐ N ☐
Irritability Y ☐ N ☐
Mood swings Y ☐ N ☐
Migraines Y ☐ N ☐
Night sweats Y ☐ N ☐
How have you dealt with these symptoms? _____
_____

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Have you experienced any weight gain in the past 1-2 years? Y ☐ N ☐ If yes, please describe:

_____

_____

Have you ever had your testosterone level taken? Y ☐ N ☐ If yes, please describe (when, result if known, etc) _____

_____

List current medications: _____

_____

Do you initiate intercourse? Y ☐ N ☐

Is intercourse satisfying? Y ☐ N ☐

Do you achieve orgasm? Y ☐ N ☐

Do you suffer from premature ejaculation? Y ☐ N ☐

How often do you have intercourse? _____

Do you have erectile dysfunction: Y ☐ N ☐ If yes, please describe: _____

_____

Is your sex drive the same as it was 5 years ago? If no, please describe: _____

_____

_____ _____

Patient Name Date

_____

Signature

THANK YOU!

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Male Testosterone Acknowledgment Form

Although Pellet Hormone Therapy has been approved for human use, there are relatively few doctors who currently administer testosterone pellets in the United States. I realize that this is not the usual and customary means of prescribing testosterone. I realize that the advantages of testosterone for men often include: a) behavioral changes including decreasing depression, decreasing anxiety and irritability, increasing energy and motivation, stabilizing mood, allowing one to cope better, improving one's self-image and self-worth, and enhancing one's stamina; b) improvement in one's cognitive function, i.e. reducing "brain fog", improving short-term memory and allowing one to stay focused to complete a task; c) physical effects such as decreasing total body fat, increasing lean body mass, increasing muscle mass, and increasing bone mass; and d) sexual benefits such as increasing libido, increasing early morning erections, increasing firmness and duration of erections.

I realize there are potential concerns with testosterone therapy and they include the possibility of enhancing a current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test and possibly a digital rectal exam should be done annually. If there is any question about possible prostate cancer, I consent to a follow-up with an ultrasound of the prostate gland.

I realize that there is an issue with male athletes abusing testosterone. When taking large quantities of *SYNTHETIC* testosterone, there may be resultant heart problems and elevated cholesterol. However, low dose, non-oral, natural testosterone that is used in bio-identical hormone therapy has not been associated with these problems.

Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood count may be done at least annually, and it is suggested that patients donate blood, a worthy endeavor, 1-3 times annually to prevent blood thickening from occurring.

Especially in younger men, testosterone administration can suppress the development of sperm and sperm count could dramatically reduce while a person is on testosterone therapy. However, to date, this appears to be, in the majority of men, a reversible process. Once the testosterone is discontinued, the sperm count is restored, usually in 6 - 12 months. This is an extremely important point to be aware of, in particular for younger men taking testosterone therapy. In this early stage, we have encouraged them to produce samples and have them frozen, just in case there is any permanent long-term effect on their situation. We have encouraged any men who are concerned about their fertility in the future to have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone administration is not to be used as a form of male contraception.

My signature certifies that I have read the above and acknowledge I have been encouraged to ask any questions regarding testosterone pellets. Individual results may of course vary.

_____ _____

Patient Signature Date

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CONSENT FOR HORMONE IMPLANTATION

I, _____ authorize Nael Dagstani, NMD, to perform sterile minor surgical placement of hormone pellets under the skin.

I understand the reason for the procedure is hormone therapy using estradiol and/or testosterone hormones.

I acknowledge that risks of this minor surgical procedure include possible infection and/or bleeding, among others.

LOCAL ANESTHESIA is used and involves risk, most importantly a rare risk of reaction to medication causing death.

I consent to the use of such anesthetics as may be necessary.

I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

_____ _____

Patient Signature Today's Date

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HIPAA - Health Insurance Portability and Accountability Act

YOUR RIGHTS - Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION - You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES - With your written consent we may disclose to family members, close personal friends or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without our authorizatrion, in the following circumstances: For public health activities (reporting of disease, injury, birth, death or suspicion of child abuse, neglect, or other domestic violence)

- To government authority if we believe an individual is a victim of abuse, neglect or domestic violence
- For health oversight activities (for example audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)
- For judicial or administrative proceedings (i.e. pursuant to a court order, subpoena or discovery request)
- For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)
- To avert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution
- For compliance with workers compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose HIV/AIDS related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

_____ _____

Patient signature Date

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Medicare and Medicaid Waiver

Acknowledgment and Agreement: This office does not accept or bill to Medicare or Medicaid. In exchange for the Services, the Patient agrees to make cash (credit or debit card) payments to Wellspring Restorative Health. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services including, blood-work and laboratory services even if covered by Medicare Part B
- Patient is not currently in an emergency or urgent health care situation
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services including, blood-work and laboratory services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted
- Patient agrees to reimburse Physician for any costs and reasonable attorneys fees that result from violation of this Agreement by Patient or his beneficiaries

Patient Name	Date of Birth	Todays Date
_____	_____	_____

_____ _____

Signature

Please bring a copy with you to your appointment, if you are unable to complete on a computer. PLEASE DO NOT FORGET THEM. Additional questions can also be emailed to: drdagstani@gmail.com or we can be reached at 480-861-3916. Thank you!

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