



**Bioidentical Hormone Replacement (BHRT)  
Medical History Form Males**

**This form is confidential. Please fill out completely.**

**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name Prefer to be called** \_\_\_\_\_

**Address** \_\_\_\_\_ **City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Sex** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age** \_\_\_\_\_ **Race** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Work** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Preferred Contact Method** Cell Home Email Work

**May we leave a message on a home machine, voice mail or send text?** \_\_\_\_\_

**Social Security Number XXX-XX-** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Language Preferred** \_\_\_\_\_ **Ethnicity** \_\_\_\_\_

**Marital status:** S M D W **Spouse's Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_

**Phone number** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

**Who referred you to our practice?** \_\_\_\_\_

**Pharmacy name** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

Describe the main reason for your visit today:

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How long have you been experiencing these symptoms?

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Any other symptoms associated with your chief complaint?

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Have you found anything that makes your symptoms better or worse?

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Does this problem affect your daily life? How?

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Have you ever received treatment for your symptoms? Yes/ No If yes, please list the physician and treatment including medication. \_\_\_\_\_

### Social History

(please circle yes or no)

Do you smoke? Yes or No If yes, # packs per day \_\_\_ How long? \_\_\_\_\_ Past Smoker? Yes / No

Do you use smokeless tobacco? Yes or No If yes, how long? \_\_\_\_\_

Do you drink alcohol? Yes or No If yes, how much and how often? \_\_\_\_\_

Caffeine Use? Yes or No If yes, please state amount and frequency. \_\_\_\_\_

Do you use recreational drugs such as Cocaine, Marijuana or Methamphetamine? If yes, please list the drug name and frequency: \_\_\_\_\_

Do you exercise? Yes/ No If yes, please describe your exercise habits.

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### Medical History

Are you allergic to any Medication? Yes/No If yes, list the medication and reaction.

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Do you take any medication? Yes/ No. If yes, please list (include herbal medication)

Medication	Dosage	Frequency

**Have you been hospitalized or undergone a surgical procedure? Yes/ No If yes, please list:**

**Surgery/Illness**

**Date**

**Physician**

**Hospital**

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<b>MENTAL HEALTH</b>	<b>YES</b>	<b>NO</b>
Is stress a major problem for you?		
Do you feel depressed often?		
Do you panic when stressed?		
Do you have problems with your appetite?		
Do you cry often?		
Have you ever attempted suicide?		
Have you ever thought about injuring yourself?		
Do you have difficulty sleeping?		
Have you ever seen a Counselor/Therapist?		

**If you have ever received in patient treatment for a mental health illness or for substance abuse Yes/ No please explain:**

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**Please answer the following by Checking Yes or NO Box:**

**YES**

**NO**

1. Do you have a decrease in sex drive?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/endurance?		
4. Have you lost Height		
5. Have you noticed a decreased in enjoyment of life?		
6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. During sexual intercourse, has it been more difficult to maintain our erection to completion of intercourse?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

**Have you ever or are you experiencing any of the following? (Check all that apply)**

**Constitutional Symptoms**

- Weight gain \_\_\_lbs
- Night Chills
- Weight loss \_\_\_lbs
- Night Sweats
- Fatigue
- Appetite change

**Eyes**

- Glaucoma
- Vision loss
- Blurred/Double vision

**Ear/Nose/Throat/Mouth**

- Hearing loss
- Nasal congestion
- Snoring
- Mouth/throat irritation
- Tooth problems

**Respiratory**

- Shortness of Breath
- Cough
- Wheezing

**Cardiovascular**

- Chest pain/Pressure
- High/Low blood pressure
- Heart Racing/Palpitations
- Heart Failure
- Heart attack
- Sweating
- Ankle swelling
- Syncope/Passing out

**Gastrointestinal**

- Nausea/Vomiting
- Abdominal Pain
- Constipation
- Diarrhea
- Blood in Stool
- Liver disease
- Difficulty Swallowing
- Heartburn

**Integumentary**

- Skin Rash
- Dry Skin
- Eczema

**Genitourinary**

- Urinary retention
- Pain with urination
- Kidney Disease
- Incontinence
- Urinary frequency
- Urinary hesitancy
- Sexual problems
- Vaginal dryness
- Vaginal discharge
- Frequent UTIs

**Neurological**

- Depression/Anxiety
- Stroke
- Insomnia
- Headache/Migraine
- Dizzy
- Seizures
- Bipolar disorder

**Hematologic/Lymphatic**

- Swollen glands
- Easy bleeding or DVT treatment
- Blood

**Musculoskeletal**

- Muscle Wasting
- Arthritis
- Pain
- Stiffness
- Weakness

**Endocrine**

- Change in Sex Drive
- Cold or Heat
- Thyroid Problems
- Blood Sugar Problems
- Change in Body Hair
- Excessive Thirst

I have not experienced any of the symptoms above

**I/My Family has a history of: (please check all that apply)**

	Me	Family	Comment		Me	Family	Comment
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hormone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes, Type1or2	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Overactive Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	GERD/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spine Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	STDs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	_____						

**If there is anything not listed on this form that you feel the provider should be aware of please list here:**

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**I (the patient) agree to submit this medical history as accurately, completely, and to the best of my recollection. I agree that failure to provide truthful, accurate and complete information on this history form to 1513, LLC to the physicians of 1513, LLC could result in inappropriate treatment. I also understand that this record submitted will be held in the highest confidentiality as set by the Health Information Act as well as other established law and will only be used to further my medical treatment.**

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**Print Name**

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**Signature**

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**Date**

**Reviewed by** \_\_\_\_\_

## VENIPUNCTURE/INJECTION CONSENT FORM

I understand the general risks associated with this therapy may include, but are not limited to bruising, soreness, pain, local swelling, redness, and possible infection when the skin barrier is compromised; these are potential risks with any injection.

I understand that there are risks both known and unknown to any medical procedure, treatment, or therapy and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these unknown risks.

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Signature

Date

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Witness

Date



## HIPAA NOTICE OF PRIVACY PRACTICES

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

The terms of this Notice of Privacy Practices (“Notice”) apply to 1513, LLC, its affiliates, and its employees. 1513, LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by 1513, LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (“HIPAA”). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address shown at the bottom of this notice.

### USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

**Authorization and Consent:** Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**Uses and Disclosures for Treatment:** We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

**Uses and Disclosures for Payment:** We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Health Care Operations:** We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

**Individuals Involved In Your Care:** We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

**Appointments and Services:** We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

**Other Uses and Disclosures:** We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law.
- Public health activities such as required reporting of immunizations, disease, injury, birth, and death, or in connection with public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- To your employer when we have provided health care to you at the request of your employer.
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings.
- Court or administrative ordered subpoena or discovery request.
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To coroners and/or funeral directors consistent with law.
- If necessary, to arrange an organ or tissue donation from you or a transplant for you.
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

## **DISCLOSURES REQUIRING AUTHORIZATION:**

**Marketing:** We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value. **Sale of Protected Information:** We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities.
- Research purposes if we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes.



- Treatment and payment purposes.
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence.
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures.
- Disclosures required by law.
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

## **RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:**

**Access to Your Protected Health Information:** You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" by calling the Privacy Officer at (706) 221-4848. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

**Amendments to Your Protected Health Information:** You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" by calling the Privacy Officer at (706) 221-4848.

**Accounting for Disclosures of Your Protected Health Information:** You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

**Restrictions on Use and Disclosure of Your Protected Health Information:** You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Practice Name] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

**Right to Notice of Breach:** We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

**Paper Copy of this Notice:** You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address shown at the bottom of this notice.

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer at 1513, LLC. To file a complaint with 1513, LLC Please contact 706-221-4848. All complaints must be submitted in writing to 3075 Tower Road Ste F, Columbus, GA 31909. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, Washington, D.C. 20201, calling 1-877-696-6775 or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). There will be no retaliation for filing a complaint.

**For Further Information:** If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the 1513, LLC Privacy Officer by phone at (706) 221-4848 or at the following address: 1513, LLC 3075 Tower Road Suite F Columbus, GA 31909

1513, LLC

3075 Tower Road Suite F. Columbus GA 31909

706-221-4848

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: \_\_\_\_\_

Patient Birth Date: \_\_\_\_\_

We at 1513, LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

\_\_\_\_\_  
Signature of patient or patient's representative/parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's representative/parent

\_\_\_\_\_ Relationship to patient

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ Notice of Privacy Practice Given- Patient is unable to sign

\_\_\_\_\_ Notice of Privacy Practice Given-Patient refused to sign