1513 WELLNESS & WEIGHT LOSS
3075 Tower Road Suite F Columbus, GA 31909 | 706.221.4848

Bioidentical Hormone Replacement (BHRT)

Medical History Form – Males

Patient Name: _____ Gender _____ D.O.B. _____

First Name Middle Initial Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Race: _____ AGE: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Employer: _____

Who to call for an emergency?

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Preferred Pharmacy: _____ **Address:** _____ **Phone** _____

How did you hear about us?

☐ Internet ☐ Social Media ☐ Patient Referral ☐ Billboard ☐ GYM

Friend/Relative Name: _____ Other: _____

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MISSED APPOINTMENT POLICY

CANCELLATION OF AN APPOINTMENT

To be respectful of the medical needs of other patients, please be courteous and call the office at least 24hours in advance if you are unable to show up for an appointment. Our appointment times are in high demand, and your early cancellation will allow another patient access to timely medical care.

To cancel, please call 706-221-4848 and speak with one of our schedulers. If it is after hours, please leave a detailed message on our voicemail.

NO SHOW POLICY

A “no show” is defined as a patient who misses an appointment without cancelling in a minimum of 24 hours in advance for all provider and Mira Vita appointments. A failure to be present at the time of an appointment will be recorded in the patient charge as a “no show.” This includes arriving more than 15 minutes after the scheduled appointment time. In the event of a “no show” **1513 Wellness & Weight Loss** “may” charge the credit card on file a **$25 missed appointment fee**. This fee “may” be charged for missed appointments or appointments cancelled in let than 24 hours’ notice. We require that all patients to have a credit or debit card on file. We allow two no show appointments before considering a patient for termination from the practice. Those arriving more than 10 minutes late to their appointment may be asked to reschedule.

By signing this statement, I acknowledge that I understand and agree to abide by the terms of the Missed Appointment Policy

Signature: _____ **Date:** _____

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OUTSTANDING BALANCE & CREDIT CARD ON FILE POLICY

RETURNED CHECK POLICY

We require that all patients to have a credit or debit card on file. In the event of a check being returned for insufficient funds, we will charge the card on file for the returned check and a $25 returned check fee.

OUTSTANDING BALANCE POLICY

Any patient carrying an outstanding balance will be responsible for paying in full before seeing or being treated by a provider. Balances that reach 90-days past due will be referred to a collection agency. The collection agency will have the authority to collect the full outstanding balance due to us plus a 25% collection fee.

CREDIT CARD ON FILE POLICY

Effective 01/01/2022 you will be asked to place a credit card on file at the time you check in. The information will be held securely until your insurance/s have paid their portion and notified us of the remaining amount. At that time, the remaining balanced owed by you will be charged to your credit card and a copy of the charge will be mailed to you. This policy will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

We are under HIPPA policies, which means we are under strict rules and guidelines for protecting patients' privacy and your credit card is considered protected health information.

By signing this statement, I acknowledge, understand, and agree to abide by the terms of the medical practices Outstanding Balance and Credit Card Policy

Signature: _____ **Date:** _____

☐ **VISA** ☐ **MC** ☐ **DISCOVER** ☐ **AMEX**

Card Number: _____ **Exp Date:** _____

CCV: _____ **Billing address:** _____

I certify that I am the authorized holder and signatory of the credit card referenced above. I hereby authorize **1513 Wellness & Weight Loss** to charge the above credit card for collection of payment and charges for missed appointments within this form.

Printed Name: _____ **Date:** _____

Signature: _____

If you have questions or concerns, please ask to speak to an office manager.

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CONFIDENTIALITY OF PATIENT MEDICAL RECORDS &HIPPA ACKNOWLEDGMENT

We understand that information about you, your health, and your healthcare is personal. We are committed to protecting your personal health information (PHI). We request that you sign this form acknowledging that you have been given the opportunity to read and receive a copy of our policy regarding the confidentiality of patient medical records. This acknowledgment will be filed within your medical records.

I acknowledge that I have been given the opportunity to receive and read a copy of this organizations HIPPA privacy policy.

Printed Name: _____ **Date:** _____

Signature: _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI via phone call, text or email may be provided to you and to the designated relative or friend on a voice mail at the number you provide to this office.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below on voice mail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

Patient Name: _____ **Date:** _____ / _____ / _____

Phone Number: (___) _____ **Cell phone number**: (___) _____ **Work Number**: (___) _____

Email Address: _____

Relative / Friend 1) Name: _____ **Phone:** _____

Relative / Friend 1) Name: _____ **Phone:** _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship to Patient: _____

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MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Name of Primary Care Provider (PCP): _____

Current/Past Specialty Providers: _____

List your top 3 concerns for today's visit:

_____

_____

_____

Allergic To:	Reaction

Allergic to: Latex: ☐ Yes ☐ No Lidocaine: ☐ Yes ☐ No Betadine: ☐ Yes ☐ No

Medication	Dose	Reason for taking	Prescriber

Past Medical History:

_____

_____

_____

GU History (Male):

History of **impotence, BPH, prostate cancer or testicular cancer**? If so please explain:

Any current or previous treatments with hormones? YES/NO If yes, describe including positive or negative effects

Preventative Health History: Please enter dates of most recent and details if abnormal.

Preventative Test	Date	Normal	Abnormal	History of Abnormal Details
Bone Density				
Colonoscopy				
Rectal Exam				
Chest X-Ray				

Surgical and Hospitalization History:

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Family History:

List family members with the following health conditions. Please circle if cause of death.

- ☐ Heart Disease: _____
- ☐ Heart Attack before age 50: _____
- ☐ High Blood Pressure: _____
- ☐ Diabetes: _____
- ☐ Thyroid Disorder: _____
- ☐ Mental Illness: _____
- ☐ Genetic Disorder: _____
- ☐ Breast Cancer: _____
- ☐ Ovarian Cancer: _____
- ☐ Colon Cancer: _____
- ☐ Other: _____

Tobacco Use circle one, add details if needed

☐ **Has never smoked tobacco**

☐ **Former Smoker:** Year quit _____ Year's smoked _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

☐ **Current Smoker:** Desire Quitting? ☐ Yes ☐ No Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No if yes, how many drinks per week? _____

Do you have previous or current problems with alcohol? _____

Substance abuse:

Recreational drug use? ☐ Yes ☐ No Details _____

Prescription drug abuse? ☐ Yes ☐ No Details _____

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FAMILY HISTORY QUESTIONNAIRE:
Common Hereditary Cancer Syndromes

Instructions: This is a **screening tool** for the common features of hereditary cancer syndromes.

- Please note all 1st, 2nd, and 3rd degree relatives.
- *Mother/Father/Sister/Brother/Children* = **1st Degree Relatives**
- *Aunt/Uncle/Grandparent/Niece/Nephew* = **2nd Degree Relatives**
- *Cousin/Great Grandparent* = **3rd Degree Relatives**

Y	N	BREAST AND OVARIAN CANCER DIAGNOSIS	RELATIONSHIP Maternal or paternal	AGE AT
☐	☐	Breast cancer at age 45 or younger (in self, 1st or 2nd degree relatives)		
☐	☐	Ovarian Cancer at ANY AGE (in self, 1st or 2nd degree relatives)		
☐	☐	Two relatives with Breast Cancer on the same side of the family, one occurring before age 50		
☐	☐	Three or more relatives with Breast Cancer On the same side of the family ANY AGE		
☐	☐	Bilateral Breast Cancer at ANY AGE		
☐	☐	Triple Negative Breast Cancer under the age of 60 (receptor status negative for ER, PR HER2)		
☐	☐	Male Breast Cancer at ANY AGE		
☐	☐	Pancreatic Cancer with 2 or more Breast and/or		
☐	☐	Ovarian Cancers on the same side of the family		
☐	☐	A family member with a known BRCA Mutation (or in self)		
☐	☐	Jewish family member ANY AGE		
☐	☐	Are you Ashkenzai Jewish?		
☐	☐	COLON AND UTERINE CANCER		
☐	☐	Uterine Cancer before age 50		
☐	☐	Colorectal Cancer before age 50		
☐	☐	Two or more of the following cancers on the same Side of the family:		
☐	☐	Colon, Uterine (endometrial)		
☐	☐	Ovarian, Stomach, Small Bowel, Brain, Kidney/		
☐	☐	Urinary Tract, Ureter,or Pelvis ANY AGE		
☐	☐	A family member with a known Lynch Syndrome Mutation (or in self)		

Patient's Signature: _____ **Date:** _____

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Patient Name: _____ Date: _____

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

Answer YES or NO to each of the following questions:	YES	NO
1. Do you have a decrease in libido (sex drive)?	☐	☐
2. Do you have a lack of energy?	☐	☐
3. Do you have a decrease in strength and/or endurance?	☐	☐
4. Have you lost height?	☐	☐
5. Have you noticed a decreased "enjoyment of life?"	☐	☐
6. Are you sad and/or grumpy?	☐	☐
7. Are your erections less strong?	☐	☐
8. Have you noticed a recent deterioration in your ability to play sports?	☐	☐
9. Are you falling asleep after dinner?	☐	☐
10. Has there been a recent deterioration in your work performance?	☐	☐

If you answered **YES** to questions **1** or **7** or any **3 other questions**, you may be experiencing androgen deficiency (low testosterone level).