Through our desire to provide you with the most focused and personalized healthcare experience, we would like to understand the primary reason that has brought you to the center today. Please take a moment to identify which of the following you are hoping to achieve through your care at Rejuve Health Clinics.

(Please assign a numerical value from 1-6 to each goal in order of importance)

☐ Improve Energy ☐ Weight Loss ☐ Improve Physical Stamina/Endurance

☐ Increase in Sex Drive ☐ Improve Sexual Function ☐ Management of Chronic Illness:
(Cardiovascular disease, Type II diabetes, other)

Patient Information:

How did you hear about our clinic? _____

First name: _____ Last name: _____

M.I. _____ Preferred Name: _____

Address: _____

City, State, Zip: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

SS#: _____ Email: _____

Home Number: _____ Cell: _____

May we send you a text message to remind you of your appointment? **YES** **NO**

Emergency Contact: _____ Number: _____

I authorize the medical staff of Rejuve Health Clinics to obtain a blood sample expressly for the purpose of determining my testosterone and PSA levels, as well as any additional appropriate laboratory testing.

Signature_____ Date: _____

Report of Medical History

Patients Name: _____

Statement of patient's present health:
Medications Currently Used:
Allergies:

Have you ever?			Do you?		
YES	NO	(please check each item)	YES	NO	(please check each item)
		Lived with anyone who had tuberculosis			Wear glasses or contacts
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

Have you ever or do you now have?

YES	NO	Don't Know	(Please check each)	YES	NO	Don't Know	(please check each)	YES	NO	Don't Know	
			Scarlet fever, erysipelas				Cramps in legs				Foot trouble
			Rheumatic fever				Frequent indigestion				Neuritis
			Swollen or painful joints				Stomach, liver, intestinal trouble				Paralysis (include infantile)
			Frequent sever headaches				Gallbladder or gallstones				Epilepsy or fits
			Dizziness or fainting spell				Jaundice or hepatitis				Car, Train, or Sea sickness
			Eye trouble				Adverse reaction to serum, drug, or medicine				Frequent trouble sleeping
			Ear, nose, throat trouble				Broken bones				Depression or excessive worry
			Hearing loss				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Chronic or frequent colds				Rupture/hernia				Nervous trouble
			Sever tooth or gum trouble				Piles or rectal disease				Periods of unconsciousness
			Sinusitis				Frequent or painful urination				
			Hay fever				Bed wetting since age 12				
			Head injury				Kidney stones or blood in urine				
			Skin disease				Sugar or albumin in urine	**FEMALES ONLY**			
			Thyroid trouble				VD-Syphilis, gonorrhea, etc				Been treated for female disorders
			Tuberculosis				Recent gain/loss of weight				Had a change in periods
			Asthma				Arthritis, rheumatism, bursitis				
			Shortness of breath				Bone, joint, or other deformity				
			Pain or pressure in chest				Lameness	**Are you (Check one)**			
			Chronic cough				Loss of finger or toe				
			Palpating / pounding heart				Painful shoulder or elbow	☐ Right Handed			
			Heart trouble				Recurrent back pain	☐ Left Handed			
			High/low blood pressure				Locked knee				

Patient History Questionnaire (Circle Yes or No)

Past History: (Circle Yes or No)

Yes **No** Do you have or have you ever had thyroid disease? **If yes, date:** _____

Yes **No** Do you have or have you ever had diabetes? **If yes, date:** _____

Yes **No** Do you have or have you ever had asthma or lung disease? **If yes, date:** _____

Yes **No** Do you have or have you ever had acne or dry/oily skin? **If yes, date:** _____

Yes **No** Do you have or have you ever had venereal diseases? **If yes, date:** _____

Yes **No** Have you ever had an abnormal PSA test or prostate exam? **If yes, date:** _____

Yes **No** Have you ever had any surgery on the prostate or genital area? **If yes, date** _____

Yes **No** Do you have or have you ever had high blood pressure? **If yes, date:** _____

Yes **No** Have you ever had a heart attack or stroke? **If yes, date:** _____

Family History: (Circle Yes or No)

Yes **No** Do you have any blood related family members with breast cancer?

Yes **No** Do you have any blood related family members with prostate cancer?

Yes **No** Do you have any blood related family members with diabetes?

Yes **No** Do you have any blood related family members with cardiovascular disease?

Social History (Circle Yes or No)

Yes **No** Do you use tobacco? **If yes, how much:** _____

Yes **No** Do you drink alcoholic beverages? **If yes, how much/how often:** _____

Signature: _____ Date: _____

Hormone Replacement Questionnaire **(Circle Yes or No)**

Yes **No** Have you experienced muscle weakness, fatigue, or loss of muscle mass?

Yes **No** Has your interest in sex (libido) declined?

Yes **No** Has your energy level or stamina declined?

Yes **No** Have you lost self confidence or motivation?

Yes **No** Have you experienced loss of memory or concentration ability?

Yes **No** Have you experienced sleep disturbances or difficulty breathing while asleep?

Yes **No** Do you have mood swings or depression?

Yes **No** Have you noticed an increase of aggression?

Yes **No** Do you have any breast tenderness or enlargement?

Yes **No** Do you have periodic hot flashes or sweats?

Yes **No** Have you experienced difficulty achieving pregnancy?

Yes **No** Are you considering having any (or more) children?

Signature: _____ Date: _____

ACKNOWLEDGEMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our **Notice of Privacy Practices**. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. This applies to the privacy practices of **Rejuve Health Clinics Inc**. You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested by asking out front desk.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that **Rejuve Health Clinics Inc.** can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker:

_____	_____	_____
FULL NAME	SIGNATURE	DATE

Relationship to resident/patient/legal authority (if applicable)

_____	_____	_____
FULL NAME	RELATIONSHIP	DATE