MALE PATIENT INTAKE FORM

First & Last Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact Number: _____

Email: _____

Driver License Number: _____

Occupation: _____

Height: _____ Current Weight: _____ Goal Weight: _____ BP (if known): _____

Birth Date: _____ Age: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: Single ■ Married ■ Divorced ■ Widowed ■ Domestic Partnership ■

Primary Physician: _____ Last Visit: _____

Major Hospitalizations / Operations / Illnesses:

_____

Primary Symptoms / Concerns:

FAMILY HISTORY INFORMATION

Check all that apply (self / family):

■ Abnormal Blood Pressure
■ Arthritis / Joint Problems
■ Asthma / Bronchitis
■ Autoimmune Disease
■ Blood Disorders / Anemia
■ Cancer / Tumors / Cysts
■ Colitis
■ Crohn’s Disease
■ Depression / Mental Illness
■ Diabetes
■ Eczema / Psoriasis
■ Endocrine Disorder
■ Epilepsy
■ Excessive Bleeding
■ Gallstones
■ Heart Disease
■ Herpes / Cold Sores
■ HIV
■ Hepatitis
■ Jaundice / Liver Disease
■ Kidney Infections
■ Emphysema
■ Melanoma / Skin Cancer
■ Pneumonia
■ Recurring Infections
■ Rheumatic Fever
■ Thyroid Disease
■ Tuberculosis
■ Seizures
■ Stroke
■ Ulcers

MALE HORMONE HISTORY

Are you presently serving or have served in military? Yes ■ No ■

Prostate Exam Date: _____

Colonoscopy Date: _____

Cardiac Stress Test Date: _____

PSA Test Date: _____ Results: _____

Current Hormones (Testosterone, HGH, HCG): _____

Previous Hormones Taken: _____

Sexual Enhancement Drug Use (Viagra, Cialis): _____

Normal Bedtime: _____ Normal Wake Time: _____

Trouble Falling Asleep? Yes ■ No ■ Sometimes ■

Do you wake up tired? Yes ■ No ■ Sometimes ■

Nighttime Awakenings: _____ times

How old do you feel? _____

Symptoms (check all that apply):

■ Loss of Strength
■ Reduced Libido
■ Loss of Muscle Tone
■ Not Physically Fit
■ Erectile Dysfunction
■ Belly Fat
■ Dry Skin
■ Irritability
■ Fatigue
■ Memory Lapses
■ Hair Loss
■ Restless Sleep
■ Anxiety

■ Urinary Problems

HEALTH INFORMATION AUTHORIZATION (HIPAA)

I authorize ApexLife Rejuvenation to use and disclose my medical records for the purpose of: Bio-identical Hormone Therapy, Andropause Treatment, Weight Loss, Stress Management, and Telehealth. I understand I may revoke this authorization at any time.

Patient Signature: _____ Date: _____