

MALE CONFIDENTIAL EVALUATION AND HEALTH HISTORY

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies and/or metabolic imbalances. The answers provided in the questions below will allow the practitioner to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

Please bring in or mail copies of the following labs you may have had within the last year:

- 1. Complete Blood Count**
- 2. Chem Screen (cholesterol, blood sugar, liver enzymes, electrolytes, etc.)**

GENERAL INFORMATION:

Date: _____

Name: _____ Age: _____ Birth Date: _____

Address (include City/State/Zip): _____ Apt. _____

Phone: (h) _____ (w) _____ (cell) _____

Occupation: _____ Full-Time Part-Time Retired Unemployed Other

Living Situation: Spouse Alone Partner Friend(s) Parents Children Other

Status: Married Single Divorced Widowed

How did you hear about Natural Hormone Replacement Therapy (HRT): Ad Another Patient Friend

Physician/Healthcare practitioner Books/Articles Class/Seminar Other

If you had a referral, who referred you? _____

Have you discussed HRT / Male Andropause with your Health Care Practitioner? _____

Do you understand what Male Andropause is? _____

What are your three main symptoms/concerns? 1. _____ Since When? _____

2. _____

3. _____

What is the age you are? _____ What is the age you feel? _____

MEDICAL STATUS:

Primary Health Care Practitioner/Physician: _____ Phone: _____

Other Physicians Currently Seeing: _____

Dentist: _____ Phone: _____

General Health: Excellent Good Fair Poor Height: _____ Weight: _____ Blood Type: _____

Drug allergies/reaction to vaccines: _____

Current Diagnosis or Medical Conditions: _____

Current Medications: _____

Current Vitamins or OTC products: **(Please list ALL products including daily dosage.)** _____

Current Herbs/etc.: _____

CURRENT AND PAST MEDICAL CONDITIONS:

Please check the ones that apply to you

	Y	N	Date of Diagnosis		Y	N	Date of Diagnosis
Asthma				Gallbladder trouble			
Arthritis				Heart Disease			
Autoimmune Disorder				High Blood Pressure			
Cancer				Irritable Bowel			
Chronic Fatigue				Kidney Trouble			
Clotting Defects				Liver Disease			
Colitis				Osteoporosis			
Dental Issues				Other (explain)			
Depression/Anxiety							
Diabetes				Stroke			
Eating Disorder				Surgeries (explain)			
Epilepsy							
Erectile Dysfunction				Ulcer			
Fractures				Varicose Veins			
Fibromyalgia				Vasectomy			

Bone Density: Y N Date: _____ Type: Back Hip T-Score: _____

Have you ever had your Thyroid tested: Y N Date: _____

TSH _____ Free T4 _____ Free T3 _____ Other _____

PSA Level: _____

HABITS:

Dietary Restrictions/Food Cravings/Intolerances: _____

Average Daily Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you regularly skip meals: Y N _____

Do you get routine exercise: Y N What type: _____ How often: _____

Do you use tobacco products: Y N How Much: _____ How Long: _____

Do you use alcohol products: Y N How Much: _____ How Long: _____

Do you use caffeine products: Y N How Much: _____ How Long: _____

Do you have a history of substance abuse: Y N _____

Daily Water Intake: _____ Drink/bathe in well water? Y N

Is there a history of trauma/abuse?: _____

Do you have a history of substance abuse?: Y N _____

FAMILY HISTORY:

	IMPORTANT DISEASES	LIVING	DECEASED
Sons			
Daughters			
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandma			
Paternal Grandpa			
Maternal Grandma			
Maternal Grandpa			

SYMPTOMS TO DETERMINE WHICH HORMONES TO TEST FOR MALES

SIGNS / SYMPTOMS FOR MALES

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test for hormone imbalance.

Estrogen Deficiency	Estrogen Excess
<input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Foggy thinking <input type="checkbox"/> Bone loss <input type="checkbox"/> Depressed <input type="checkbox"/> Apathy	<input type="checkbox"/> Prostate problems <input type="checkbox"/> Decreased urine flow <input type="checkbox"/> Increased urinary urge <input type="checkbox"/> Nervous <input type="checkbox"/> Weight Gain - hips <input type="checkbox"/> Headaches <input type="checkbox"/> Low Libido <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Elevated Triglycerides
Progesterone Deficiency	Progesterone Excess (Supplementation)
<input type="checkbox"/> Bone Loss <input type="checkbox"/> Decreased urine flow <input type="checkbox"/> Prostate problems <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Increased urinary urge <input type="checkbox"/> Decreased libido	<input type="checkbox"/> Sleepiness <input type="checkbox"/> Mild Depression

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test you Testosterone and DHEA-S.

Androgen Deficiency	Androgen Excess
<input type="checkbox"/> Low libido <input type="checkbox"/> Decreased erections <input type="checkbox"/> Fatigue <input type="checkbox"/> Aches/pains <input type="checkbox"/> Foggy thinking <input type="checkbox"/> Decreased flexibility <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Prostate problems <input type="checkbox"/> Decreased mental ability <input type="checkbox"/> Arthritis <input type="checkbox"/> Depressed <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Bone loss <input type="checkbox"/> Decrease muscle mass <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Decreased stamina <input type="checkbox"/> Decreased urine flow <input type="checkbox"/> Increased urinary urge <input type="checkbox"/> Burned out feeling	<input type="checkbox"/> Loss of scalp hair <input type="checkbox"/> Acne <input type="checkbox"/> Oily skin <input type="checkbox"/> Aggression <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious

Check which of these symptoms are troublesome and persist over time. One or more of these symptoms in this category is a strong indication that you need to test your Cortisol.

Cortisol Deficiency	Cortisol Excess
<input type="checkbox"/> Fatigue <input type="checkbox"/> Sugar craving <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical sensitivity <input type="checkbox"/> Stress <input type="checkbox"/> Cold body temperature <input type="checkbox"/> Heart palpitation <input type="checkbox"/> Aches/pains <input type="checkbox"/> Arthritis <input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Bone loss <input type="checkbox"/> Weight gain – waist <input type="checkbox"/> Loss of muscle mass <input type="checkbox"/> Thinning skin <input type="checkbox"/> Elevated triglycerides <input type="checkbox"/> Anxiety <input type="checkbox"/> Tired but wired feeling <input type="checkbox"/> Low libido <input type="checkbox"/> Increased forgetfulness <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable

SIGNS / SYMPTOMS FOR MALES

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication that testing **IGF-1** for imbalances of human growth hormone (HGH) is recommended.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor or declining | <input type="checkbox"/> Thickened heel pads |
| <input type="checkbox"/> Memory lapses | <input type="checkbox"/> Premature aging | <input type="checkbox"/> "quality of life" | <input type="checkbox"/> Changes in skull/face |
| <input type="checkbox"/> Decreased muscle mass | <input type="checkbox"/> Weight gain-waist | <input type="checkbox"/> Slowing cognition | <input type="checkbox"/> Enlarged/thickened |
| <input type="checkbox"/> Decreased stamina | <input type="checkbox"/> Bone loss | <input type="checkbox"/> Decreased exercise | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Thinning/sagging skin | <input type="checkbox"/> capacity | <input type="checkbox"/> Chronic neurological |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Visual field defects | <input type="checkbox"/> conditions |
| | <input type="checkbox"/> Insulin resistance | <input type="checkbox"/> Thickened palms | |

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication of the need to test for Thyroid Dysfunction by testing **ft4, ft3, TSH, and/or TPO OR Complete Thyroid Profile.**

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Decreased muscle mass | <input type="checkbox"/> Bulging eyes |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Slow pulse rate | <input type="checkbox"/> Thinning skin | <input type="checkbox"/> Erratic behavior |
| <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Decreased sweating | <input type="checkbox"/> Infertility problems | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Slowed reflexes | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Hair dry or brittle | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Can't lose weight | <input type="checkbox"/> Nails breaking or brittle | <input type="checkbox"/> Thick tongue | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Memory lapses | <input type="checkbox"/> Aches/pains | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Decreased mental |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> sharpness |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Bone loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Swelling/puffy eyes | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Unusual sweating | <input type="checkbox"/> Rapid heartbeat |
| <input type="checkbox"/> and/or face | | <input type="checkbox"/> Always feeling hot | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Sleep disturbances | | | <input type="checkbox"/> Tremors in fingers |

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication that testing **Fasting Insulin** is recommended for indications of Insulin Resistance, Metabolic Syndrome and Pre-diabetes.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Food/sugar cravings | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Weight gain – waist | <input type="checkbox"/> Increased urinary urge | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Numbness (hands and |
| <input type="checkbox"/> Difficulty sleeping | | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> feet) |

Initials

Telephone Questions to the Practitioner

1. Since the practitioners are not in the office every day, it is possible you may not have a return call or voice mail response that same day.
2. Due to the volume of phone calls and each individual's differing degree of severity of health care needs, a reserved telephone appointment with the practitioners may be necessary at the rate below.
 - a. These telephone/email fees will be explained to you in advance of the phone consult and billed to your credit card account.

Initials

Fee Structure

Initial Consult with Carolyn Walker	60- 90 minutes with NP	\$350 (includes 30 minutes with RN nutrition consultant)
Follow Up Visits with Carolyn Walker (may include phone consults)	60minutes - 1 Hour (usual)	\$100 / 30 minutes, \$200 / hour
Nutrition Nurse (RN) Consultant --accepts checks/cash only	1 st 30 minutes Non-NP Consultation, extended or follow-up consults	No Charge when included in initial NP Consult fees \$50 / 30 minutes, \$100 / hour (minimum 1/2 hour)
Phone Consult / Email Time (CRW)	\$3.00 / minute	Depends on # of minutes
Correspondence / Letters to Insurance	\$25 per each 15 minutes	Depends on # of minutes
Copying	.25 per sheet	Depends on # of copies

Initials

Payment/Reimbursement of Services

Although Prevention & Healing of Iowa's NPs do not contract with health insurance carriers, we do provide the following to assist you in filing for reimbursement with your particular carrier:

1. A statement itemizing payment of services.
2. A medical claim form delineating services provided, by whom, with diagnostic and procedure codes.
3. A cover letter directing your insurance provider to direct reimbursement to you.
4. Should your insurance ultimately deny reimbursing your for our services, you may be able to submit medical expenses through an employer-sponsored flex spending plan.

I agree with the above informed consent, child care, cancellation / scheduling / fee structure / telephone / payment / reimbursement of services / email / copying policy.

Please Sign Here: _____ **Date:** _____

<u>OFFICE USE ONLY:</u>	
Date Received:	<input type="checkbox"/> HIPPA
Appt. Date: _____ Time: _____	<input type="checkbox"/> Vital Info. Form
	<input type="checkbox"/> Health History Form