



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

Patient Signature

Date



Patient History Questionnaire (circle Yes or No)

- Yes No Have you had any muscle weakness, fatigue or loss of muscle mass?
Yes No Has your interest in sex (libido) declined?
Yes No Do you have spontaneous erections (without medication or other aid)?
Yes No Has your energy level or stamina declined?
Yes No Have you lost self confidence, motivation or initiative?
Yes No Has there been any decline in memory or concentration ability?
Yes No Have you had any sleep disturbance or problems breathing while asleep?
Yes No Do you have mood swings or depression?
Yes No Have you noticed any increase in aggressiveness?
Yes No Do you have any breast tenderness or enlargement?
Yes No Have you lost any hair in the genital or underarm areas?
Yes No Has your need to shave decreased?
Yes No Have you noticed any significant change in the size of your testicles?
Yes No Do you have periodic hot flashes or sweats?
Yes No Have you ever had problems achieving a pregnancy?
Yes No Are you considering having any (or more) children?

Past History (circle Yes or No)

- Yes No Have you ever had an abnormal PSA test or prostate exam?
Yes No Do you have or have you ever had thyroid disease, diabetes, high blood pressure, asthma/lung disease, acne, dry or oily skin, or any venereal disease?
Yes No Do you have any allergies to any medications? If yes, list on back of page.
Yes No Do you take any medications on a daily basis? If yes, list on back of page.
Yes No Have you ever had any surgery in the prostate or genital area?
If yes, list on back of page.

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? _____

Patient Signature

Date



Review of Systems: Please check any that apply.

Ears, Nose, and Throat

- Hearing Loss
- Ringing in Ears
- Altered Sense of Smell
- Trouble Swallowing
- Neck Pain/Stiffness

Lungs

- Nonproductive Cough
- Pain with Breathing at Rest
- Pain with Breathing with Exertion
- Pain with Inspiration
- Wheezing
- Coughing up Blood
- Short of Breath with Exertion

Cardiovascular System

- Chest Pain/Pressure at Rest
- Chest Pain/Pressure with Exertion
- Heart Palpitations
- Normal Tolerance to Exercise
- Pain in Legs with Walking
- Cold Hands/Feet
- Fainting
- Lightheadedness

Hematology (Blood)

- Anemia
- Hemochromatosis

Allergic

- Hives

Gastrointestinal System

- Pain with Swallowing
- Abdominal Pain
- Nausea
- Vomiting

Neurological System

- Headache
- Loss of Sensation in any Part of Body
- Weakness of any Extremity
- Uncontrolled Muscle Movements
- Dizziness
- Problems with Walking
- Speech Disturbance

Genitourinary System

- Pain with Urination
- Urinary Frequency
- Urinary Urgency
- Blood in Urine
- Trouble Starting Stream

- Difficulty Stopping Stream

- Erectile Dysfunction

Musculoskeletal System

- Joint Pain (any Joint)
- Pain in any Muscles
- Muscle Weakness

General Constitution

- Fatigue
- Night Sweats
- Weight Loss
- Weight Gain

Integumentary (Skin) System

- Rashes

Psychiatric

- Depressed
- Anxious/Nervous

Endocrine

- Goiter (Lump in Neck)
- Appetite Change
- Heat or Cold Intolerance

Eyes

- Headache
- Blurry Vision
- Double Vision
- Visual Changes

AUA SYMPTOM SCORE (AUASS) AND QUALITY OF LIFE (QOL)

PATIENT NAME: _____

TODAY'S DATE: _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. _____

TOTAL:

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6



WELCOME TO THE LOW T CENTER!

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 the Low T Center.

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

Improved Energy

Improved Physical Stamina/Endurance

Increase in Sex Drive

Improved Sexual Function

Weight Loss

Management of a Chronic Illness (Cardiovascular Disease, Type II Diabetes, other)

PATIENT INFORMATION

How did you hear about our clinic? _____

Last Name _____ First Name _____ M Initial _____

Preferred Name _____

Address _____

City/St/Zip _____ Date of Birth _____

Age _____ Height _____ Weight _____ SS _____

Email _____

Home Phone _____ Cell _____

Preferred method of contact _____

Employer _____ Work Phone _____

Work Address _____ City/State/Zip _____

May we send you a text message reminder the day before your appointment? (Circle One) YES NO

(We will not send you any other text messages without prior approval.)

POLICY HOLDER INFORMATION (if different than yourself)

Last Name _____ First Name _____ M Initial _____

Relationship _____ Date of Birth _____

SS# _____ Home Phone _____

Cell _____ Employer _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____



PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received and reviewed the privacy practice notice (3 pages) for Low T Center, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature

Date

Print the Patient Name



FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to Low T Center, LLC for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Low T Center, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Low T Center, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient / Responsible Party Signature

Date

Print the Patient Name

Witness

Date