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Dr. Tad Connine, Medical Director

Male Hormone Replacement Therapy Packet

Ocala, FL ~ Tampa, FL

Patient Demographics

LAST NAME:	FIRST NAME:	M.1.
D.O.B.	GENDER:	MARITAL STATUS:
SOCIAL SECURITY NO.:	PREFERRED LANGUAGE:	
RACE:		ETHNICTY:
HOME ADDRESS:		
CITY:	STATE:	ZIP:
PHONE #1:	PHONE #2:	
EMAIL:		
EMPLOYER:	WORK PH:	
ALLERGIES (Medical Alert):		
PRIMARY CARE PHYSICIAN:	PHONE:	
REFERRING PHYSICIAN:	PHONE:	
PHARMACY NAME:	PHONE:	
ADDRESS:		
CITY:	STATE:	ZIP:
IN CASE OF EMERENCY CONTACT:		
FIRST NAME:	LAST NAME:	
RELATION	PHONE	
INSURANCE INFORMATION - PRIMARY		
Insured Name:	Relationship to Patient:	DOB:
Insurance Company:	PHONE:	
Insurance Company Address:		
CITY:	STATE:	ZIP:
Policy No.	Group No.	Employer:
INSURANCE INFORMATION - SECONDARY		
Insured Name:	Relationship to Patient:	DOB:
Insurance Company:	PHONE:	
Insurance Company Address:		
CITY:	STATE:	ZIP:
Policy No.	Group No.	Employer:

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Padgett Medical Center, LLC. I assign and authorize payments to the Padgett Medical Center. LLC, I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I. am responsible for fees not paid in full copayments and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

I give permission to leave phone message(s): _____*YES* _____*NO*

_______________________________________ _______________________

Patient and or/Guardian Signature Date

Ocala, FL ~ Tampa, FL

Padgett Medical Center - Female Packet

Patient Name: ______________________________ **Date of Birth:** ____________________

Medication History

List ALL medications: prescription, over-the-counter, supplements, and vitamins.

MEDICATION	DOSAGE	DOSING SCHEDULE

Allergies

List all allergies and reactions. (including medications, substances, seasonal, etc.)

ALLERGY	REACTION

Family History

List all illnesses (heart disease, stroke, diabetes, hypertension, cancer – type, etc.)
If a family member is deceased, please list age of death and cause, if known.

Relationship	Age	Medical Problem(s)/Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember, this information is strictly confidential.
It will be used **only** to address your symptoms and/or complaints.

Do you smoke cigarettes? _____Currently _____Past History _____Never
If yes, how many per day? _______________ How long have you smoked, total? ___________________

Do you drink alcohol? _____Currently _____Past History _____Never
If yes, how of each type do you have in an average week?
Beer: _______ per week Wine: _______ per week Spirits: _______ per week
How long have you been drinking, in total? ____________________

Do you use illicit drugs (marijuana, cocaine, amphetamines, non-prescribed opiates or narcotics, LSD/acid, etc.)?
_____Currently _____Past History _____Never
If currently or in the past, list the substances used, and how often they are/were used.

____

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____

Urological History

Last Prostate Exam: Date: ____________________
Physician Name:____ Ph#: ____________________
Have you ever had an abnormal Prostate Exam? _______ YES _______ NO
If yes, what was the abnormality and what follow-up did you have? ________________________

____

Last Mammogram: Date: ____________________
Physician/Facility Name:___________________________________ Ph#: ____________________
Have you ever had an abnormal mammogram? _______ YES _______ NO
If yes, what was the abnormality and what follow-up did you have? ________________________

____

Have you ever had a elevated PSA? _______ NO _______ YES, Date: ___________________
If yes, what was the result, and what follow-up did you have, if any? _______________________

____

Have you ever had a prostate biopsy? _______ NO _______ YES, Date: ___________________
If yes, what was the result, and what follow-up did you have, if any? _______________________

____

Do you have a history of any of the following cancers? Circle those which apply to you. _____ NONE APPLY

Breast Colon Leukemia Lung Lymphoma Prostate Skin

Other ____

Hormone Therapy History

Have you been treated with any hormone replacement therapy? _____ YES _____ NO
If yes, give type, reason, and periods of treatment.

HORMONE	DOSE	REASON	START DATE	STOP DATE

Androgen Deficiency

Check which of these symptoms are troublesome and have persisted over time

- ☐ Apathy/Decreased Passion for Life
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Erections
- ☐ Decreased Muscle Mass
- ☐ Decreased Strength/Energy
- ☐ Fall Asleep After Dinner
- ☐ Hair Loss
- ☐ Lack of Energy
- ☐ Lost Height
- ☐ Low Libido
- ☐ Problem with Memory/Concentration
- ☐ Recent Deterioration of Work Performance
- ☐ Sad or Grumpy
- ☐ Sleep Disturbances

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess

- ☐ Acne
- ☐ Anxious
- ☐ Bone Loss
- ☐ Breast Cancer
- ☐ Cold Body Temperature
- ☐ Elevated Triglycerides
- ☐ Fatigue
- ☐ Hair Loss
- ☐ Headaches
- ☐ Heart Palpitation/Arrhythmia
- ☐ Irritable
- ☐ Increased Body Hair
- ☐ Increased Facial Hair
- ☐ Loss of Muscle Mass
- ☐ Low Libido
- ☐ Memory Lapses
- ☐ Nervousness
- ☐ Sleep Disturbances
- ☐ Stress
- ☐ Sugar Cravings
- ☐ Thinning Skin
- ☐ Weight Gain – Waist

Cortisol Deficiency

- ☐ Aches/Pains
- ☐ Allergies
- ☐ Arthritis
- ☐ Chemical Sensitivity
- ☐ Cold Body Temperature
- ☐ Exhaustion/Fatigue
- ☐ Heart Palpitations
- ☐ Irritable
- ☐ Stress
- ☐ Sugar Craving

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency	
☐ Coarse Dry Skin	☐ Aches/Pains	☐ Inability to Lose Weight
☐ Diarrhea	☐ Cold Body Temperature	☐ Lack of Motivation
☐ Difficulty Conceiving/Infertility	☐ Cold Intolerance	☐ Muscle Cramps
☐ Heart Palpitations/Arrhythmia	☐ Constipation	☐ Stress
☐ Heat Intolerance	☐ Fatigued/Weakness	☐ Unexplained Weight Gain
☐ Insomnia	☐ Irritable	
☐ Muscle Weakness		
☐ Nervousness/Anxious/Panic Attacks		
☐ Tremors/Shakiness		
☐ Voice Has Become Hoarse		
☐ Weight Loss		

System Review - Check the appropriate box for each question.

Constitutional/ID/Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory	**Yes**	**No**	**Not Sure**
Do you have a persistent cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema?			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Do you have vascular disease or artery blockages/aneurysms?			
Have you ever been diagnosed with any heart condition?			
Have you ever been diagnosed with a blood clot?			
Gastrointestinal	**Yes**	**No**	**Not Sure**
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			

System Review Continued - Check the appropriate box for each question.			
Gastrointestinal - continued	**Yes**	**No**	**Not Sure**
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine	**Yes**	**No**	**Not Sure**
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological	**Yes**	**No**	**Not Sure**
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision of blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic/Renal	**Yes**	**No**	**Not Sure**
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had kidney problems?			

Past Medical History

List any medical problems or illnesses you have had or have.
Include any hospitalizations and accidents with approximate dates.

Date	Medical Diagnosis, Illness, Accident, etc.

Past Surgical History

List any surgeries, and the dates they were performed.

Date	Surgery Description

Present Symptoms

Briefly describe your symptoms. What do you feel is the most important factor to your present symptoms?

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Physician Notes: ______________________________________

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Disclosure/Liability Waiver
Padgett Medical Center, LLC – Bio-Identical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing. views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable. and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Padgett Medical Center, LLC, it's staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand it is a release of liability.

I accept all terms and conditions of this program.

______________________________	______________________________
Signature of Patient	Today's Date
______________________________	______________________________
Printed Name of Patient	Date of Birth