Paradigm Hormones Restorative Clinic – Male New Patient Info

Name: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ City/State/Zip: _____
Phone #: _____ Email: _____ SSN: _____
Occupation: _____ Employer: _____
How did you hear about us? _____
Marital Status (Please Circle): **Married** **Separated** **Divorced** **Single** **Widow**
Children: Y/N If yes, how many? _____ Do you desire more children? Y/N

Emergency Contact Info:
Name: _____
Relationship: _____ Phone: _____

Medication List:

_____ _____ _____
_____ _____ _____

Drug Allergies: Y/N If yes, please list: _____

Are you currently/have you ever used any form of hormone replacement therapy? Y/N
If yes, please circle: Gel Cream Shots Pellets Other

Main Concerns/Reason for Visit:

- ☐ Fatigue
- ☐ Decreased Libido
- ☐ Erectile Dysfunction
- ☐ Decreased Muscle Mass
- ☐ Weight Concerns
- ☐ Other: _____

Please circle any of the following symptoms you have been experiencing if any:

Metabolic

Weight Gain:	Yes	No	# of pounds per year _____		
Increased Blood Pressure:	Yes	No	Mild	Moderate	Severe
Increased Blood Sugar:	Yes	No	Mild	Moderate	Severe

Musculoskeletal

Decrease in muscle size, tone, strength:	Yes	No	Mild	Moderate	Severe
Decrease in physical capabilities/performance:	Yes	No	Mild	Moderate	Severe

Mental Function

Fatigue, especially in the afternoon:	Yes	No	Mild	Moderate	Severe
Decrease in mental sharpness:	Yes	No	Mild	Moderate	Severe

Sexual Function

Lack of morning erections:	Yes	No	Mild	Moderate	Severe
Decreased Libido:	Yes	No	Mild	Moderate	Severe
Erectile Dysfunction:	Yes	No	Mild	Moderate	Severe

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Social History – (Please circle Yes/No)

Smoker: Y/N	If yes, how many per day? ____ How many years? _____
Do you chew/dip tobacco? Y/N	If yes, how many times per day? ____
Do you use recreational drugs? Y/N	If yes, please explain: _____
Do you drink alcohol? Y/N	If yes, how many drinks per week? _____
Do you exercise? Y/N	
Do you consume caffeine? Y/N	

Family History			LIST THE FAMILY MEMBER & AGE DIAGNOSED BELOW
Breast Cancer:	YES	NO	_____
Ovarian Cancer:	YES	NO	_____
Colon Cancer:	YES	NO	_____
Lung Cancer:	YES	NO	_____
Skin Cancer:	YES	NO	_____
Kidney Disease:	YES	NO	_____
Diabetes:	YES	NO	_____

Preferred Pharmacy

Location Name: _____

Address: _____

Phone #: _____

Primary Care Physician

Facility/Location: _____

Physician Name: _____ Phone: _____

Address: _____ Fax: _____

NOTICE OF PRIVACY PRACTICES

Paradigm Hormones has privacy practices in place. The notice describes how medical information about you may be used and disclosed, and how you can get access to this information. By signing this, you acknowledge receipt of Paradigm Hormones Notice of Privacy Practices.

Signature: _____ Date: _____

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Medical History

Please mark any of the following that you have experienced or are currently experiencing:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Blood Diseases
- ☐ Blood Transfusions
- ☐ Bone Problems
- ☐ Breast Cancer
- ☐ Cardiomyopathy
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Hair Loss
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Iron
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Joint Problems
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Muscle Problems
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Seizers/Epilepsy
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Varicosities
- ☐ Water Retention
- ☐ Other: _____

Surgical History

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Colonoscopy
- ☐ Gall Bladder Removal
- ☐ Knee Surgery
- ☐ Rhinoplasty
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Wisdom Teeth Removal
- ☐ Other: _____

Review of Systems
Please Circle Yes/No:

CONSTITUTIONAL

Fever	YES	NO
Night Sweats	YES	NO
Weight Gain	YES	NO
Weight Loss	YES	NO
Exercise Intolerance	YES	NO

EYES

Dry Eyes	YES	NO
Irritation	YES	NO
Vision Change	YES	NO

EAR/NOSE/THROAT

Difficulty Hearing	YES	NO
Ear Pain	YES	NO
Frequent Nose Bleeds	YES	NO
Nose Problems	YES	NO
Sinus Problems	YES	NO
Sore Throat	YES	NO
Bleeding Gums	YES	NO
Snoring	YES	NO
Dry Mouth	YES	NO
Oral Abnormalities	YES	NO
Mouth Ulcer	YES	NO
Teeth Abnormalities	YES	NO

CARDIOVASCULAR

Chest Pain	YES	NO
Arm Pain	YES	NO
Shortness of Breath	YES	NO
Palpitations	YES	NO
Heart Murmur	YES	NO
Light-headed	YES	NO

RESPIRATORY

Cough	YES	NO
Wheezing	YES	NO
Shortness of Breath	YES	NO
Coughing up Blood	YES	NO
Sleep Apnea	YES	NO

GASTROINTESTINAL

Abdominal Pain	YES	NO
Vomiting	YES	NO
Change in Appetite	YES	NO
Black/Tarry Stools	YES	NO
Frequent Diarrhea	YES	NO
Vomiting Blood	YES	NO
Dyspepsia	YES	NO
GERD	YES	NO

GENITOURINARY

Urinary Loss of Control	YES	NO
Difficulty Urinating	YES	NO
Increased Urinary Frequency	YES	NO
Hematuria	YES	NO
Incomplete Emptying	YES	NO

MUSCULOSKELETAL

Muscle Aches	YES	NO
Muscle Weakness	YES	NO
Joint Pain	YES	NO
Back Pain	YES	NO
Swelling in Extremities	YES	NO

INTEGUMENTARY

Abnormal Mole	YES	NO
Jaundice	YES	NO
Rash	YES	NO
Itching	YES	NO
Dry Skin	YES	NO
Growths/Lesions	YES	NO
Laceration	YES	NO

NEUROLOGIC

Loss of Consciousness	YES	NO
Weakness	YES	NO
Numbness	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Frequent/Severe Headaches	YES	NO
Migraines	YES	NO
Restless Legs	YES	NO
Tremor	YES	NO

PSYCHIATRIC

Depression	YES	NO
Sleep Disturbances	YES	NO
Restless Sleep	YES	NO
Alcohol Abuse	YES	NO
Anxiety	YES	NO
Hallucinations	YES	NO
Suicidal Thoughts	YES	NO

ENDOCRINE

Fatigue	YES	NO
Increased Thirst	YES	NO
Hair Loss	YES	NO
Increased Hair Growth	YES	NO
Cold Intolerance	YES	NO

HEMATOLOGIC/LYMPHATIC

Swollen Glands	YES	NO
Easy Bruising	YES	NO
Excessive Bleeding	YES	NO

ALLERIC/IMMUNOLOGIC

Runny Nose	YES	NO
Sinus Pressure	YES	NO
Itching	YES	NO
Hives	YES	NO
Frequent Sneezing	YES	NO

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Request for Release of Protected Health Information (HIPPA)

This form will be used to release your protected health information as required by federal and state privacy laws. Your authorization allows Paradigm Hormones to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Paradigm Hormones. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Your Information:

Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Phone: _____

SSN: _____

I authorize my physicians, medical professionals, Paradigm Hormones, and its agents/affiliates to release my protected health information as described below:

Recipient: _____

Relationship: _____ Phone: _____

Address: _____

Manner of Release:

- ☐ Records shall be made available for Pick-up only
- ☐ Records shall be mailed to recipient to: _____
- ☐ Records shall be faxed to recipient to: _____
- ☐ Records shall be emailed to recipient to: _____
- ☐ Any of the above

Description of Information to be Released:

- ☐ Lab Results
- ☐ All Medical Records
- ☐ Specific information as described: _____

Purpose of Release:

_____

This authorization will expire (please check one of the following):

- ☐ When I revoke this authorization
- ☐ On this date, event or condition: _____

"I affirm all the information supplied is true and correct. I further understand that this authorization to release information is voluntary and is not a condition of treatment, eligibility for benefits, or payment or claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. I request that Paradigm Hormones release the protected health information described above to the persons and/or entities listed above for the purposes set forth above."

_____ _____

Signature **Date**

CO-PAY / DEDUCTABLE/ CO-INSURANCE NOTICE:

Financial agreement: Payment of all copays, deductibles, and/or coinsurance are due at the time of service. As a service to you, our office will bill your insurance company if you desire. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances.

If your deductible HAS been met, you will only be responsible for your copay and any coinsurance your insurance requires. (unless your out-of-pocket has been met for the year.)

If your deductible HAS NOT been met, Paradigm will apply your insurance's contracted amount and you will be responsible for 100% of amount due at the time of service.

All self pay patients are 100% responsible for every visit for the agreed upon amount with the billing department.

Payment policy: Payment is expected at the time of services are rendered. For your convince we accept cash, Visa, Mastercard, American Express and Debit cards. Arrangements must be made for the payment of any balance greater than $200.

Signature:_____ Date:_____

Prescription Policy: Paradigm diagnosis and treats hormonal conditions. These medications when properly used can help patients feel better and lead more productive lives. Our policy:

1. Written prescriptions will NOT be replaced if lost, stolen or misplaced
2. Prescriptions are to be taken as directed. DO NOT change the frequency of the dose unless otherwise directed by a Paradigm professional. If a change does occur it will be documented in your chart.
3. Refills of prescriptions may be refilled every 3 months. If you have not been seen in those 3 months we have the right to refuse refills until you are seen by Paradigm staff.
4. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough to last you.
5. Prescription requests before noon will be available at your pharmacy after 5pm that day. Requests made after 12 noon will be available at your pharmacy after 10am the following morning.

Initialing will state you agree to adhere to the rules above._____ Initial

natera | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 484848.

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:			Age at diagnosis	Enter family member and age at diagnosis		
			You	Siblings/Children	Mother's side	Father's side
Example:	Breast cancer	☒ Y ☐ N	Age 46	Daughter, 23 Sister, 52	Aunt, #1 63 Aunt, #2 48	Grandma, 81
1. Breast cancer ≤ age 45 **OR** breast cancer ≤ age 50 with unknown family history		☐ Y ☐ N				
2. Either colon cancer or uterine cancer < age 50		☐ Y ☐ N				
3. Triple negative breast cancer ≤ age 60		☐ Y ☐ N				
4. Two or more breast cancers in the same person (first diagnosis ≤ age 50)		☐ Y ☐ N				
5. Two or more colon and/or uterine cancers in the same person		☐ Y ☐ N				
6. Two family members with breast, colon or uterine cancer (one ≤ age 50)		☐ Y ☐ N				
7. Three or more family members from the same side with breast cancer		☐ Y ☐ N				
8. Three or more family members with colon and/or uterine cancer		☐ Y ☐ N				
9. Ovarian cancer **OR** pancreatic cancer **OR** male breast cancer **OR** 10 or more precancerous colorectal polyps		☐ Y ☐ N				
10. Ashkenazi Jewish **AND** breast cancer or high-grade prostate cancer		☐ Y ☐ N				
11. You or a close family member has a known gene mutation. Please list _____		☐ Y ☐ N				
12. Other cancers not listed above _____		☐ Y ☐ N				
13. Other concern about your cancer risk	Please explain:	☐ Y ☐ N				

If you have never been diagnosed with breast cancer, please complete the following questions.

1. Height (ft/in) _____ **2.** Weight (lbs) _____ **3.** Have you had children? ☐**Y** ☐**N** How old were you when you had your first child? _____

4. Approximate age at first menstrual period? _____ **5.** Have you gone through menopause? ☐**Y** ☐**N** ☐**Ongoing** If yes, at approximately what age? _____

6. Are you of Ashkenazi Jewish descent? ☐**Y** ☐**N** ☐**I don't know**

7. Have you ever used hormone replacement therapy? ☐**Y** ☐**N** If yes, when? Start date _____ Ongoing? ☐**Y** ☐**N** End date _____

If yes, what type? ☐ **Estrogen** ☐ **Progesterone** ☐ **Combined**

8. How many sisters do you have? _____ Daughters? _____ Maternal aunts? _____ Paternal aunts? _____ ☐ **I don't know**

9. Have you ever had a breast biopsy? ☐**Y** ☐**N** If yes, what was the result? ☐ **Hyperplasia** ☐ **Atypical hyperplasia** ☐ **LCIS** ☐ **I don't know**

Signatures

Patient Name	Patient Signature	Date
Provider Name	**Provider Signature**	**Date**

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing
(check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

   201 Industrial Road, Suite 410 | San Carlos, CA 94070 | www.natera.com | 1.650.249.9090

Consent to Have Blood Drawn:

I authorize the medical staff of Paradigm Hormones LLC to obtain a blood sample for the purpose of running any laboratory testing they deem necessary as determined in the professional discretion of the medical staff.

_____

Signature/Date

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Paradigm Hormones.

_____

Signature/Date

Consent to Order Medical/Prescription History

I authorize the medical staff of Paradigm Hormones LLC to obtain my past medical and prescription history. In order to help with my treatment.

_____

Signature/Date

Consent to Contact

I give consent to Paradigm Hormones to contact me to discuss different aspects of my visits. I understand that some of the reasons they may be contacting me is to discuss lab results, appointment reminders, billing etc.

_____

Signature/Date