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Men's Health Patient Questionnaire and History

Name:______________________ ___________________ _________________Today's Date:_____________
(Last) (First) (Middle)

Date of Birth:_____________Age:_________Weight:_____________ Occupation: ________________________

Home Address:____

City:____ State:_________ Zip:_____________

Home Phone:_____________________ Cell Phone:______________________Work:____________________

E-Mail Address:____ May we contact you via EMail? ( ) YES ( ) NO

In Case of Emergency Contact:_________________________________Relationship:_____________________

Home Phone:______________________Cell Phone:______________________Work:_____________________

Primary Care Physician's Name:_____________________________________Phone:_______________________

Address:____
Address City State Zip

Who may we thank for referring you to our clinic? ____

I want to unlock exclusive offers by subscribing to the monthly newsletter

- ☐ Yes
- ☐ No

I ____grant my permission for the use of photographs, videos or case information for the following Bubolo Medical clinical purposes as indicated by my checked box below:

- ☐ Allow my picture to be used with identifying information
- ☐ Only allow my pictures to be used without identifying who I am
- ☐ I do not want any of my photos and or videos used

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Medical History

Any known drug allergies: ____

Medications Currently Taking: ____

Current Hormone Replacement Therapy: ____

Past Hormone Replacement Therapy: ____

Nutritional/Vitamin Supplements: ____

Surgeries, list all and when: ____

Other Pertinent Information: ____

Date of Last Prostate Exam:_______________ Results:____

Current or History of STD's:____

Medical Illnesses:

( ) High blood pressure
( ) High cholesterol
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or pulmonary emboli
( ) Hemochromatosis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer (type): _______________________________
Year: ______________

( ) Testicular or prostate cancer
( ) Elevated PSA
( ) Prostate enlargement
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis

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Evaluation:

1. Present Weight:_____________ Height:___________ Desired Weight:______________
2. In what time frame would you like to be at your desired weight? __________________________
3. What is the main reason for your decision to lose weight? ________________________________

____

4. When did you begin gaining excess weight?(Give reasons, if known)_________________________

____

5. What has been your maximum lifetime weight and when:____________________

____

6. Previous Diets you have followed:____

____

7. Give dates and results of previous weight loss attempts:__________________________________

____

8. Is your spouse, fiancé or partner overweight? Yes No
9. Do you awaken hungry during the night? Yes No
10. How often do you eat out? ____
11. How often do you eat "fast food"? ____
12. Do you wake up in the morning hungry? ____
13. What time of the day are you most hungry? ____
14. What is your level of activity?

- ☐ **Inactive**- No regular physical activity with a sit down job
- ☐ **Light Activity**- No organized physical activity during leisure time
- ☐ **Moderate Activity**- Occasionally involved in activities such as weekend gold, tennis, jogging, swimming, or cycling
- ☐ **Heavy Activity**- Consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
- ☐ **Vigorous Activity**- Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

15. On an average how many hours of sleep do you get per night? ______________________

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Symptom Survey

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

Heart Disease ( ) No ( ) Yes

Diabetes ( ) No ( ) Yes

Osteoporosis ( ) No ( ) Yes

Alzheimer's Disease ( ) No ( ) Yes

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Informed Patient Consent

During your visit the doctor may perform one or more diagnostic tests. The first test is an Echo Doppler ultrasound which measures the blood flow through the penis. Your doctor will locate the cavernous artery in the penis and measure "passive" blood flow (when you are not sexually aroused). In the next step, the doctor often uses an auto applicator to apply medication to the spongy tissue of the penis. This is a painless procedure. The medication consists of a combination of common vasodilators, including Prostaglandin E1, Papaverine, Phentolamine, and Atropine. The medications will increase the blood flow to the vascular system (similar to when you are sexually excited), which could result in a partial, or up to a full, erection.

On a rare occasion, the medications may produce a full erection lasting (4) four hours or more, called a priapism. A priapism is unusual and ordinarily occurs only in patients who are highly sensitive to the combination of vasodilators used. If this should occur, you will be advised on the procedures to follow. Treatment for the same will be provided to you at our clinic at no extra cost. By following our priapism treatment protocol and receiving proper treatment, patients will not suffer long-term effects. HOWEVER, if you DO NOT FOLLOW our proper Priapism Protocol, it might result in temporary or permanent damage to the penis. You will receive other precautionary literature at your initial appointment that provides detailed information. Other rare side effects of this procedure might be, slight bruising and/or lightheadedness, usually as a result of nervousness.

I accept the risk and potential complications of the procedure.

I, ______________________, (Please print your name), fully understand the nature of the tests described above and their possible side effects. I am aware that purchases of any other medication I elect are final and nonrefundable. **I understand that I will not be entitled to a refund from Bubolo Medical for any reason, including poor outcomes. Prescription Drugs are NON REFUNDABLE PER FEDERAL LAW. ALL CHARGES ARE FINAL.** I consent to treatment by the Bubolo Medical Men's Health Physician indicated below. I am aware of the possibility of experiencing aforementioned conditions as a result of the treatment. I acknowledge these services are considered to be elective treatments, and they are not covered by Medicare. However, some private insurance companies may cover a portion of the cost. Any medications ordered by me are non-returnable in accordance with applicable laws.

______________________	______________________	______________
Print Name	**Signature**	**Date**

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Please encircle the response that best describes you for the following five questions:

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very Low 1	Low 2	Moderate 3	High 4	Very High 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost Never or Never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost Never or Never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely Difficult 1	Very Difficult 2	Difficult 3	Slightly Difficult 4	Not Difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost Never or Never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: ______________1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM

1. I authorize Bubolo Medical to disclose my protected health information to:
    - ❑ **Family member(s)**

Name	Phone Number

- ❑ **Non- Family Members**

Name	Phone Number

- ❑ **Myself Only**

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

    - ❑ Test results, reports, and general health updates
    - ❑ Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

Email Address:
Phone Number:

Expiration or termination of authorization – This authorization will remain in effect until terminated by the patient's personal representative, or another individual or legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Director.

By signing below, I acknowledge that I have received, reviewed, understood, and will comply with the policies and procedures explained in the Bubolo Medical Office Policies and Procedures for Patients form.

Patient Signature ______________________________________ **Date** __________________________

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Office Policies & Procedures For Our Patients

OFFICE HOURS

Our office is available Monday - Thursday 9:00am - 6:00pm and Fridays 9:00am - 1:00pm. We close daily for lunch from 1:00pm - 3:00pm. We can be reached in Acworth at 770-975-1299 and Sandy Springs at 404-255-6000.

Our answering services are available "after hours" 24 hours per day/365 days per year by calling our phone number and following the prompts. If you need an appointment, prescription refill or test results, please call during regular business hours.

APPOINTMENTS & WALK - INS

Bubolo Medical is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates.

While we strive to schedule appointments appropriately, emergencies can and do occur in healthcare. We strive to give all of our patients the time they require. For this reason, we kindly request your patience and understanding should delay or rescheduling become necessary on your appointment date. We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late.

We will do our best to provide you with same - day office visits and accept walk - INS for first available slots for visits. Please let our staff know if you have had any information changes since your last visit. You will be asked to fill out new registration forms annually so we may update your information.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Synergy Medical Centers promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients.

- Closings will be displayed on our website bubolomedical.com and on our Facebook/Instagram page
- If you are scheduled for an appointment, you will receive a message by telephone.

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, the release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of $0.75 per page. The law allows Medical Offices 30 days to complete requests for records.