New Patient History

NAME ______________________________ DATE ____/______/____

PHONE ____________________ EMAIL ____________________

ADDRESS ____________________ CITY ______________ STATE______ ZIP________

DOB ____________________ AGE _____REFERRED BY____________________

ALLERGIES ______________________________

OCCUPATION ______________________________

PRESENT COMPLAINTS *(Please check "Yes" or "No")*

YES	NO		
☐	☐	FATIGUE	HOW LONG?____________
☐	☐	LOW SEX DRIVE	HOW LONG?____________
☐	☐	WEIGHT GAIN	HOW LONG?____________
☐	☐	DIFFICULTY SLEEPING	HOW LONG?____________
☐	☐	POOR MUSCLE TONE	HOW LONG?____________
☐	☐	MUSCLE WEAKNESS	HOW LONG?____________
☐	☐	ERECTILE DYSFUNCTION	HOW LONG?____________

MEDICAL HISTORY *(Please check "Yes" or "No")*

YES	NO		IF YES ...
☐	☐	HIGH BLOOD PRESSURE	PROBLEM?____________
☐	☐	HEART ATTACK	HOW LONG?____________
☐	☐	FAMILY HISTORY/HEART PROBLEMS	WHEN?____________
☐	☐	PREVIOUS HEART DISEASE	PROBLEM?____________
☐	☐	HEART CATHETERIZATION	WHEN?____________
☐	☐	HEART FAILURE	HOW LONG?____________
☐	☐	DIABETES	
☐	☐	IRREGULAR PULSE	
☐	☐	HEART MURMUR	
☐	☐	NOSE BLEEDS	
☐	☐	STROKE	
☐	☐	HIGH CHOLESTEROL	
☐	☐	THYROID PROBLEMS	
☐	☐	GASTROINTESTINAL PROBLEMS	
☐	☐	HEPATITIS	
☐	☐	BLEEDING (WITH BOWEL MOVEMENTS)	
☐	☐	ANEMIA	
☐	☐	ARTHRITIS	
☐	☐	SEIZURES	
☐	☐	SWALLOWING PROBLEMS	
☐	☐	COLONOSCOPY	
☐	☐	CANCER HISTORY (TYPE) ____________	
☐	☐	HISTORY OF BLOOD CLOTS OR DVT'S	

PAST MEDICAL HISTORY

Illnesses ______________________________

____

____

Current medications ______________________________

____

Past use of Hormones ______________________________

____

Operations ______________________________

____

☐ **I would like to receive Email, SMS / Text communications, appointment reminders, and promotions. I understand that data rates may apply. You may opt out of these messages at any time**

SOCIAL HISTORY

TOBACCO USE ☐ YES ☐ NO ☐ PAST
TYPE ☐ CIGARETTES ☐ CIGARS ☐ CHEWING TOBACCO
AMOUNT ______________________ HOW LONG? ________________ WHEN DID YOU QUIT? ____________________________________

ALCOHOL USE ☐ YES ☐ NO ☐ PAST

#DRINKS DAILY __________________________________WEEKLY ________________ MONTHLY _________________________________

CAFFEINE USE ☐ YES ☐ NO ☐ PAST

AMOUNT DAILY _________________________________CUPS ________________ CANS/BOTTLES ______________________________

FAMILY HISTORY

FATHER AGE :__________ DECEASED AGE:________________ REASON:____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASCULAR DISEASE
☐ OTHER ____

MOTHER AGE :__________ DECEASED AGE:________________ REASON:____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASCULAR DISEASE
☐ OTHER ____

BROTHERS AGE :__________ DECEASED AGE:________________ REASON:____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASCULAR DISEASE
☐ OTHER ____

SISTERS AGE :__________ DECEASED AGE:________________ REASON:____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASCULAR DISEASE
☐ OTHER ____

CHILDREN AGE :__________ DECEASED AGE:________________ REASON:____
HISTORY OF: ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CARDIOVASCULAR DISEASE
☐ OTHER ____

(PHYSICIAN USE ONLY)

PHYSICAL EXAM

HEENT: ____
NECK: ____
HEART: ____
LUNGS: ____
ABDOMEN: ____
EXTREMITIES: ____
VASCULAR: ____

MEDICATION NOTES: ____
____
____

PHYSICIAN COMMENTS: ____
____
____
____
____

Male Andropause Questionaire

#	Symptom	None (1)	Mild (2)	Moderate (3)	Severe (4)	Extremely Severe (5)
1	Decline in feeling of general well-being (general state of health, subjective feeling)					
2	Joint pain and muscular ache (lower back pain, joint pain, pain in the limb, general back ache)					
3	Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)					
4	Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness					
5	Increased need for sleep, often feeling tired					
6	Irritability (feeling aggressive, easily upset about little things, moody)					
7	Nervousness (inner tension, restlessness, feeling fridgety)					
8	Anxiety (feeling panicky)					
9	Physical exhaustion/lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less; of having to force oneself to undertake activities)					
10	Decrease in muscular strength (feeling of weakness)					
11	Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)					
12	Feeling that you have passed your peak					
13	Feeling burnt out, having hit rock-bottom					
14	Decrease in beard growth					
15	Decrease in the number of morning erections					
16	Decrease in ability/frequency to perform sexually					
17	Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for intercourse)					

Print Name ______________________________

Signature ______________________________

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International Prostate Symptom Score (IPSS)

	(Circle one number on each line)	Not at all	Less than 1 time in 5	Less than half the time	More than half the time	Almost always
1	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4
2	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4
3	Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4
4	Over the past month, how often have you found it difficult to post pone urination?	0	1	2	3	4
5	Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4
6	Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4
7	Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night to the time you got up in the morning?	none	1 time	2 times	3 times	4 times
		Over 5 times				

Print Name ______________________________

Signature ______________________________

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Androgen Deficiency in the Aging Male Questionaire

1	Do you have a decrease in libido (sex drive)?	YES	NO
2	Do you have a lack of energy?	YES	NO
3	Do you have a decrease in strength and/or endurance?	YES	NO
4	Have you lost height?	YES	NO
5	Have you noticed a decreased "enjoyment of life"?	YES	NO
6	Are you sad and/or grumpy?	YES	NO
7	Are your erections less strong?	YES	NO
8	Have you noticed a recent deterioration in your ability to play sports?	YES	NO
9	Are you falling asleep after dinner?	YES	NO
10	Has there been a recent deterioration in your work performance?	YES	NO

Print Name ______________________________

Signature ______________________________

Disclaimer

The therapies offered by Rebuilding Life Orlando Testosterone and Dr. Ho are designed for the therapeutic use ONLY. Rebuilding Life Orlando Testosterone does not prescribe any medications to any professional athletes or professional bodybuilders.

I agree by signing this document that I am not undergoing care of Dr. Ho for any athletic or bodybuilding purposes.

Name____ Date ___/______/____

Signature ____

Witness Signature ____

Date ___/______/____

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No Guarantee of Services

Rebuilding Life Orlando Testosterone does not guarantee that any services or medications will be provided to you until you have undergone the full initial sign up process and physician's examination.

At the physician's discretion only, you will be provided medications and/or services during the course of your program at Rebuilding Life Orlando Testosterone.

The sign up fee is non-refundable regardless of the physician's determination on the types of services and medications that you receive during your program.

____ _____/_____/_____

Patient Signature Date

____ _____/_____/_____

Witness Signature Date

Insurance Disclosure

Rebuilding Life Orlando Testosterone does not participate with any insurance company nor will clinic staff communicate on client's behalf to any insurance company for the purposes of client billing, inquiries or reimbursement.

Medical insurance policies do not typically cover hormone replacement and related expenses, including laboratory testing, prescription medication and related supplements.

An appropriate receipt of payment will be provided, including charges and descriptions of the office visit for the different level of service provided. Insurance companies may reimburse patients for expenses related to hormone replacement therapy. Reimbursement will not be made from the insurance company to the physician or the clinic.

Please understand that Rebuilding Life Orlando Testosterone will not present a bill to any insurance company for hormone replacement services of related charges. Although Rebuilding Life Orlando Testosterone will provide a receipt, we are not obligated to complete any form that may be provided by a health insurance company.

Patient Statement Understanding

I have read and fully understand the above information related to insurance and participation in the Rebuilding Life Orlando Testosterone program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive a receipt of payment for my personal use. I understand the specifics of these receipts and limitations as described in this document.

I accept these specific policy rules.

Name ______________________________ Date ______________

Signature ______________________________

Prescription Acknowledgment

I, ________________________ (name), am voluntarily entering into hormone replacement therapy with Rebuilding Life Orlando Testosterone. (hereinafter "The Clinic"). I understand that any and all prescriptions may be filled at any pharmacy of my choice. I further understand that if I choose to fill my prescriptions at a pharmacy of my choice, I will still be responsible for the entire cost of my membership fees at The Clinic. I understand that the costs to fill my medications at a pharmacy of my choice may exceed the cost of filling my prescriptions through The Clinic, where all my medications, supplies, and shipping fees are included in The Clinic's general membership fees.

I have read and fully understand the above information related to prescriptions. I have also had the opportunity to ask questions regarding

Name____ Date ___/______/____

Signature ____

Witness Signature ____

Date ___/______/____

Notice of Privacy Practices

Rebuilding Life Orlando Testosterone

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Rebuilding Life Orlando Testosterone is permitted to disclose certain private health information without your consent or authorization in the following circumstances:

- Your financial information to carry out our business activities or for other legally allowed or required purposes;
- To provide you with medical treatment, services, or supplies;
- For health care operations, including, but not limited to, quality assessment and improvement activities, employee review and development activities, review and audit activities, management and general administration activities;
- To a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure;
- To provide you with recommendations for alternative treatments, therapists, health care providers or care setting;
- As required by law. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time. You may receive a copy of your medical records if requested in writing by you. We will also send a copy of your medical records to any third party that you designate in writing after payment of the copying fee permitted by Florida law is received.

This Notice is effective as of September 1, 2013 and may be revised without notice.
I acknowledge that I have received copies of Rebuilding Life Orlando Testosterone Notice of Privacy Practices *(if requested)*, which describes how we use and disclose your health information.

____ _____/_____/_____
Patient Signature Date

____ _____/_____/_____
Witness Signature Date

Patient Consent Form

I, ____ hereby state that by signing this consent, I acknowledge and agree as follows:

1. I am voluntarily entering into hormone replacement therapy with Rebuilding Life Orlando Testosterone ("The Clinic"). I have had the risks of this therapy explained to me and understand that there are potential health risks involved which include but are not limited to prostate cancer, high blood pressure, blood clots, heart attack, stroke and increased red blood cell count (polycythemia) which may require routine phlebotomy. I also understand that starting testosterone and or HCG can result in dependency and sterility. I will submit to routine blood testing by The Clinic to verify I am remaining compliant with my therapy. Abuse of testosterone therapy will not be tolerated by The Clinic and can result in immediate termination of my therapy.

__________ Initial

2. I agree to have an annual prostate exam done by my urologist or primary care physician. I understand that Dr. Ho does not perform prostate exams.

__________ Initial

3. I agree to hold the Clinic, its officers, agents and employees harmless from any adverse consequences that may arise from my decision to have hormone replacement therapy, and release the Clinic, its officers, agents and employees from any liability whatsoever that may arise from any adverse consequence of having hormone replacement therapy.

__________ Initial

I have read and understand the foregoing consent

____

Patient Name (please print)

Patient Signature: ____

Date: _____/_____/_______

Witness: ____

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Terms of Service & Cancellation Policy Notice

I agree to be charged a monthly fee in exchange for therapy from Rebuilding Life Orlando Testosterone. This fee will be determined by the type of therapy that I receive. Outlined below are the various tiers of therapy.

Therapy Programs

Testosterone Therapy:

1. Testosterone, hCG & Anastrozole Therapy — $200/month _____ (initial)

Recovery Therapy:

1. hCG & Anastrozole Therapy — $150____________(initial)
2. Clomid & Anastrozole Therapy — $150____________(initial)
3. hCG, Clomiphene & Tamoxifen Therapy — $325____________(initial)

GH Peptide Therapy:

1. Ibutamoren/MK677 Oral Peptide Capsules — $200/Month_____(initial)
2. Ipamorelin Peptide Injectable /Sublingual — $250/Month_____(initial)
3. Ipamorelin w/ CJC-1295 Peptide Injectable /Sublingual — $250/Month______(initial)

:

Healing / Recovery Peptide Therapy:

1. BPC-157 Oral Peptide Capsules (Gut/Inflammation) — $150/Month_____(initial)
2. BPC-157 Injectable Peptide (Injury/Healing) — $200/Month_____(initial)
3. Thymosin Alpha-1 Injectable Peptide (Immune) — $250/Month_____(initial)
4. Thymosin Beta-4 (Injury/Healing): — $250/Month______(initial)

Male Sexual Performance / ED Therapy:

1. One Month Supply Tadalafil 5 mg — $60/Month_______(initial)

Vitamin Injection Therapy:

1. Lipotropic Vitamin B12/MIC Injections (5 Injections) — $100____________(initial)
2. Glutathione Injections (5 injections) — $100____________(initial)
3. MICFat Burning Injections (5 injections) — $100____________(initial)

Cancellation Policy

Rebuilding Life Orlando Testosterone has no contract requirements and is a monthly program. We do require that you notify us no less than 30 business days prior to your renewal date to cancel membership to allow adequate time for cancellation and to incur no further charges on your credit card.

All membership cancellations must be delivered directly to the clinic.
This form can be returned via fax, email or by dropping it off to the clinic

____
Patient Name (please print)

____ ____/____/____
Signature Date

Physician Clearance Terms of Service Policy Notice

- **Initial Evaluation: $400**
  1. 1. Comprehensive blood work panel - $200
  2. Physician evaluation and consultation - $200
     A) Previous testing review if applicable
     B) Patient symptoms and concerns
     C) Review labratory results
     D) Individual therapy design and dosage determined

- **Four (4) Month Review: Varies**
  1. Comprehensive blood work panel - $200
  2. The Physician may request a physical examination if any alteration in therapy is necessary based on laboratory results - $200

- **Bi Annual Assessment: $400**
  1. Comprehensive blood work panel - $200
  2. In office review with physician - $200
     A) Review patient's treatment and clinical response
     B) Vitals and examination as applicable
     C) Review and adjustment of the individual's therapy
     D) Order revised for individual therapy when applicable

______________________________________ / / ________

Patient Signature Date

______________________________________ / / ________

Witness Signature Date

Credit Card Authorization

I authorize Rebuilding Life Orlando Testosterone to charge the listed credit card as indicated below at the conclusion of my appointment and for the monthly services I receive. We unfortunately cannot accept personal checks and apologize in advance for any inconvenience this may cause.

By signing this authorization form I agree to pay the fees as they have been described on the Terms of Service & Cancellation Policy Notice:

____ / / ______

Name   Date

____

Signature

CREDIT CARD INFORMATION :

____

Name as it appears on card

____ / ______

Credit Card Number   Expiration Date

Billing Address:

____

Street

____

City/State/Zip

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