APEX LIFESTYLE MEDICINE MEN'S INTAKE FORM

NAME:_____DATE:_____

ADDRESS:_____CITY:_____STATE:_____

ZIP: _____ CELL #: _____ HOME #:_____

DRIVERS LIC# _____ BIRTH DATE: _____

WHOM MAY WE THANK FOR REFERRING YOU:_____

EMAIL ADDRESS:_____

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPERATED

PATIENTS OCCUPATION:_____

EMERGENCY CONTACT:_____

RELATIONSHIP TO PATIENT:_____

CONTACT #: _____ ◯ CELL ◯ HOME

OCCUPATION:_____

EMPLOYER: _____

I am interested in discussing the following programs:

- ☐ Testosterone Replacement Therapy
- ☐ HGH Peptide Therapy
- ☐ MIC / Lipo-B12 / GAC / Vit D etc.
- ☐ Semaglutide Weight Loss
- ☐ _____
- ☐ PT-141
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Health History Questionnaire:

Primary Care Doctor (PCP): _____ Phone number: _____

Personal Health History – Check all that apply.

General	Diabetes	☐	High Cholesterol	☐	Unwanted Weight Loss	☐
Cancer	Personal History of Cancer	☐	Family History of Cancer	☐	Autoimmune Disorder	☐
Cardiovascular	Heart Failure	☐	Heart Attack	☐	Heart Murmur	☐
	Vascular Disease	☐	Blood Clots	☐	Edema	☐
	Hypertension	☐	Irregular Heartbeat	☐	Congestive Heart Failure	☐
Respiratory	Sleep Apnea	☐	Shortness of breath	☐	Asthma / COPD	☐
	Bronchitis	☐	Pneumonia	☐	Allergies	☐
Gastrointestinal	Lactose Intolerance	☐	Gall Bladder	☐	Gall Stones	☐
	Chronic Diarrhea	☐	Chronic Constipation	☐		
Genitourinary	Prostate Cancer	☐	Familial Prostate Cancer	☐	Overactive Bladder	☐
	Painful Urination		Decreased urinary force		On/Off Urine Flow	
	Enlarged Prostate (BPH)	☐	Blood in Urine	☐	Kidney/Bladder History	☐
Infection	Kidney /Bladder	☐	Liver	☐		
Psychiatric	History of Depression	☐	Personality Disorder	☐		

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers.

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Allergies: _____ No Known Allergies Or List Allergies and Reaction

_____

_____

Surgeries:

Year _____ Surgery/Reason _____

Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: ◯ None ◯ Mild ◯ Occasional vigorous exercise ◯ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____

_____

_____

Have you used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past? Please be completely truthful with your response, it is critical to diagnose and prescribe correctly.

_____

_____

Rate your quality of sleep: 1-Worst 10-Best

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Lifestyle Questionnaire

Alcohol: ☐ Yes Number of drinks per week: _____ ☐ No

Tobacco: ☐ Yes _____ Cigarettes ____ Cigars ____ Chewing How many/much: _____ ☐ No

Illicit drug use: ☐ Yes Explain _____ ☐ No

Vitals

Weight _____ Height_____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased concentration ◯ Yes ◯ No

Difficulty learning new things ◯ Yes ◯ No

Memory loss ◯ Yes ◯ No

Moodiness ◯ Yes ◯ No

Depression ◯ Yes ◯ No

Increasing fatigue ◯ Yes ◯ No

Decreasing energy ◯ Yes ◯ No

Daytime sleepiness ◯ Yes ◯ No

Poor sleep habits ◯ Yes ◯ No

Erectile dysfunction ◯ Yes ◯ No

I have had testosterone checked previously ◯ Yes ◯ No

I have used testosterone previously ◯ Yes ◯ No

If yes, date(s): _____ Type: _____ Usage: _____

_____

ACH Debit Authorization Form

I _____ I authorize Apex Lifestyle Medicine to charge my credit card for service not to exceed the amount shown.

PRINT FULL NAME

Lab Charge Amount: $ _____USD

Monthly Charge Amount: $ _____USD

CREDIT CARD

CARD NUMBER _____

CARD CVC _____

EXPIRATION DATE _____

BILLING ADDRESS _____

_____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____

SIGNATURE **DATE**

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT THERAPY (TRT)

It is important to understand that all medicine is an inexact science. Although we will carry out your treatment carefully, results may vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider. Please review the following statements, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all your questions to your satisfaction.

Directions: Initial beside each statement that you have read, understand and agree with.

_____1. This is my consent Apex Lifestyle Medicine, including any physician or nurse who works with the company, to begin my treatment for Testosterone Replacement Therapy.

_____2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3-#7)

_____3. Extra fluid in the body- This can cause problems for patients with heart, kidney or liver disease.

_____4. Sleep disturbance - This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.

_____5. Prostate enlargement- this may cause problems with urinating.

_____6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____7. I understand that I will have periodic blood tests to monitor my blood levels.

_____8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____9. I have had an opportunity to discuss with Apex Lifestyle Medicine and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers.

_____10. I understand that the physical exam by Apex Lifestyle Medicine does NOT replace a full physical exam by a personal physician.

_____11. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician, Apex Lifestyle Medicine will assist in locating one for me.

_____12. Family Planning for the patient has been discussed.

_____13. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility.

_____14. I have been trained on how to administer intramuscular and subcutaneous injections from a licensed medical practitioner who is approved to perform such tasks.

_____15. I agree that, while a patient of Apex Lifestyle Medicine, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by Apex Lifestyle Medicine during my treatment plan. At any time, if use of these items is discovered, I understand I will be discharged as a patient of Apex Lifestyle Medicine.

Patient Signature _____ Date_____

Witness Signature _____ Date _____

Notes: