Alabama Women's Health Care
-----OB GYN-----

Male Patient Questionnaire & 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 E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Patient Information **Alabama Women's Health Care** Date: _____

Patient Information

Patient's Name (last, first, middle) _____

Street _____

City, State, Zip_____Home Phone_____Cell Phone_____

Sex_____Birth Date_____Age_____SSN_____Driver's Lic #_____Marital Status_____

Patient's Employer_____Occupation_____Work Phone_____

Spouse's Name _____

Spouse's Employer_____Occupation_____Work Phone_____

Emergency Contact

Contact's Name_____Relationship_____Phone_____

Referring Physician

Referring Physician_____Phone_____

Insurance Information

Insurance #1_____Copay_____

Contract #_____Group #_____

Name of Insured_____Relationship to Patient_____

Sex_____Birth Date_____SSN_____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____Date_____

I hereby authorize Alabama Women's Health Care to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Alabama Women's Health Care or to the party who accepts assignment. I certify that the information I have regarding my insurance coverage is correct, In the event of outside collections, I agree to pay all collections costs, including a reasonable attorney fee.

Signature_____Date_____

Email Address_____

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Consent for Use and Disclosure of Health Information

1. This is to inform you that Alabama Women's Health Care may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your health care; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").

2. The use and disclosure of your Protected Health Information will be to carry out treatment, payment and healthcare operations of Alabama Women's Health Care.

3. For a more complete description of how Alabama Women's Health Care may use and disclose your Protected Health Information, please refer to the attached Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefor to obtain a revised Notice of Privacy Practices please contact our office.

4. You have the right to request that Alabama Women's Health Care be restricted from using or disclosing your Protected Health Information in carrying out Treatment, Payment, or Healthcare Operations; however, Alabama Women's Health Care is not required to agree to your requested restrictions. If Alabama Women's Health Care does agree to your requested restrictions, then it will comply with your request.

5. You have the right to revoke this Consent. The revocation must be made in writing to Alabama Women's Health Care. The revocation will be valid except to the extent that Alabama Women's Health Care, has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize Alabama Women's Health Care to use or disclose your Protected Health Information in conjunction with Alabama Women's Health Care's Treatment, Payment, or Healthcare Operations in accordance with the terms of this Consent.

_____ _____

Signature (Patient) Signature (Authorized Representative)

_____ _____ _____

Date Date of Birth Account Number

I have Received a copy of the Notice of Privacy Practices:_____(initials)

Further, I hereby authorize and give my consent to Alabama Women's Health Care to leave messages on my answering machine/voicemail system for the following:

_____ Appointment Reminders _____ Prescription refills

_____ Medical Information (including returned telephone calls) _____ Test Results

Further, I hereby authorize and give my consent to Alabama Women's Healthcare, to communicate any of my Protected Health Information to the following persons:

Name	Relationship

BHRT CHECKLIST FOR MEN

Name: _____ Date: _____

E-Mail: _____

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

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		