



1731 Boyson Road
Hiawatha Iowa 52233
Phone 319-363-0033 | Fax: 319-363-4411

We ask that you complete each page of the enclosed comprehensive initial consultation form and return it to us so we may schedule your initial appointment. We will call the number provided to schedule once we have received and reviewed your forms. This may take up to a week to complete. If it is convenient for you, we also request the following:

1. All laboratory results for previous 2 years – Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Cholesterol Panel (HDL, LDL, Total Cholesterol), any thyroid and/or hormone studies, any special food sensitivity testing, saliva, and/ or stool testing.
2. For women: mammograms, PAP results, and yearly exams for previous 2 years
3. For men: prostate screening and yearly exams for previous 2 years

If you are not conveniently able to locate these items and your clinician would require them to continue care, we will have to complete an authorization to release medical records form at your first appointment to obtain them. If these tests have not been completed recently, our clinician can order what she feels is necessary for you at the time of your appointment.

We also ask that you bring the following to your initial consultation:

- 1.) Most recent insurance card
- 2.) Photo ID
- 3.) List of medications and supplements. Please bring in the supplements so that we may see the ingredients and please remember to also list them on your initial paperwork.

Please arrive 15 minutes prior to your appointment. If you arrive 10 minutes or more PAST your scheduled appointment time, you may be asked to reschedule to maximize your time with your clinician.

If you are unable to keep your appointment, please call at least **72 hours in advance** of your scheduled appointment date to cancel or reschedule. Failure to show to the appointment or notify the office 72 hours in advance will result in a **no show/late cancellation fee of \$200**. Please know that we are unable to provide supervision for young children that accompany you to our clinic and we ask that you make other arrangements.

Thank you for allowing us to be a part of your health care team. We look forward to meeting you soon!

Wellness is Waiting!

Integrative Health and Hormone Clinic Staff

IMPORTANT OFFICE POLICIES

For prescription refill requests ordered by Dr. Gray simply have your pharmacy fax the request to our office at (319) 363-4411. Please allow at least ONE WEEK for this process or any other prescriptions request.

We greatly appreciate our patients, and work hard to ensure each patient is our top priority during appointments. We make every effort to respond to questions and / or concerns presented outside of an appointment within 3-5 business days.

Supplement Discount Cards are great way to save on supplements. When you spend \$200 on supplements, you will receive \$20 off your NEXT PURCHASE. Supplement Discount Cards cannot be combined with any other offer.

We make every effort to see our patients in a timely manner, but we often have many on the waiting list for an appointment time. To help us, we ask that you please notify the office 72 hours in advance if you need to change or reschedule your appointment.

A **\$200.00 NO SHOW** fee will be charged for initial appointments without the 72 hour notice. A **\$100.00 NO SHOW** fee will be charged for follow-up appointments without the 72 hour notice.

We also ask that all patients are 15 minutes early to their appointments, so we may stay on schedule and prevent patients from waiting too long when they arrive.

All specimens collected in this office are sent to LabCorp.

If you would like us to send any medical records to your primary care physician, please allow us 3-5 business days.

Thank you!

PATIENT RIGHTS AND RESPONSIBILITIES

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his/her individual dignity and with protection of his/her need for privacy.
- A prompt and reasonable response to questions and requests. Please allow at least **72 hours** for us to respond to your non-urgent questions.
- Know what rules and regulations apply to his/her conduct.
- Be given, by his/her healthcare providers, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- Receive upon request and in advance of treatment, a reasonable estimate of charges for medical care.
- **Know, upon request and in advance of treatment, that Integrative Health and Hormone Clinic is a direct-pay practice.**
- Receive a copy of a reasonable clear and understandable itemized bill and, upon request, have the charges explained.
- Receive impartial access to medical treatment or accommodations, regardless of race, color, gender, ethnicity, national origin, religion, sexual orientation, physical handicap, or source of payment.

A patient has the responsibility to:

- Provide accurate and complete health information concerning his/her illness, hospitalization, medications, supplements, allergies, and all other pertinent items. The patient should bring any information relating to his/her health to Integrative Health and Hormone Clinic at the time of the visit.
- **Understand that Integrative Health and Hormone Clinic is a specialty care provider and the services it provides are not meant to take the place of a primary care provider. Patient understands that he/she must notify his primary care provider, and any other health care provider of any and all supplements and hormones (including pellets) that Integrative Health and Hormone Clinic has prescribed, ordered, or inserted.**
- **Understand that as a specialty care provider, Integrative Health and Hormone Clinic does not offer emergency or urgent care. These services must be accessed at an urgent care facility or emergency room.**

- Participate in the development of his/her care plan, and comply with Integrative Health and Hormone Clinic policies and procedures governing his/her care. The patient understands he/she may be discharged from services from non-adherence to this plan of care.
- Voice concerns or problems to Integrative Health and Hormone Clinic staff, and to request further information concerning anything he/she does not understand.
- Be respectful of other people of Integrative Health and Hormone Clinic property. This implies that no patients will be seen under the influence of drugs or alcohol.
- Realized the consequences of his/her actions if he/she refuses treatment or does not follow medical instructions.
- Remain under medical supervision as warranted by his/her condition.
- Abide by Integrative Health and Hormone Clinic rules and regulations, and ensure that those who accompany him/her do likewise.
- Provide truthful information about insurance status, notifying Integrative Health and Hormone Clinic of changes.
- Verify coverage of his/her insurance payer for annual physical examination coverage if requesting this be provided by Integrative Health and Hormone Clinic.
- Be considerate and cooperative with Integrative Health and Hormone Clinic staff and not discriminate against health care providers because of race, color, gender, ethnicity, nation origin, religion or sexual orientation.
- Arrive for appointments on time. If you are unable to arrive on time, it may be necessary to reschedule your appointment.
- Notify Integrative Health and Hormone 72 hours in advance if he/she is unable to keep a scheduled appointment. Integrative Health and Hormone Clinic will apply a \$100 fee for all follow-up visits that are not rescheduled or cancelled 72 hours in advance.
- Permitted 1 Emergency Rescheduling: He/She will be able to reschedule 1 appointment due to an emergency within the 72 hour timeframe. He/She must reschedule in order to have the fee waived due to the emergency. Simply cancelling the appointment without the rescheduling will result in a \$100 fee.
- Fulfill personal financial obligations of his/her healthcare are promptly as possible.

By signing this document, I acknowledge that I have read and agree to all of the above statements.

Print Legal Name of Patient/Authorized Representative _____

Signature of Patient/Authorized Representative _____

Date _____

Reason why patient cannot sign (if applicable): _____

INFORMED CONSENT

Regarding Treatment and Care

I have elected to seek functional and integrative medicine treatment.

(initial)

I understand that in the practice of functional medicine some treatments are considered “alternative” by the conventional medical community and that there are some risks to treatment. I understand that some of the recommended treatments may not be approved by the FDA.

(initial)

I understand it is recommended that I see my primary care physician if I desire only FDA-approved treatments for my conditions.

(initial)

I understand that it is important that I provide accurate and complete health information concerning my illness, hospitalizations, medications, supplements, allergies, and other pertinent items.

(initial)

I understand that Integrative Health and Hormone Clinic is a specialty care provider and the services the Clinic provides are not meant to take the place of my primary care provider.

(initial)

I further understand that I must notify my primary care provider, and any other health care provider, of any and all supplements and hormones (including pellets) that IHHC has prescribed, ordered, or inserted.

(initial)

IHHC has explained the risks and benefits concerning functional and integrative medicine and I have had a chance to have my questions answered.

(initial)

Regarding Diet Recommendations and Nutritional/Herbal Supplements

I hereby request nutritional consultation and supplement suggestions.

(initial)

We may make diet recommendations and recommendations regarding use of nutritional and herbal supplements in order to supply nutrition to support the physiological and biomechanical processes of the human body. Although these foods and products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function.

(initial)

Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

(initial)

As a service to you, we make nutritional supplements available in our office. We purchase only top quality products and only from manufacturers who have gained our confidence through considerable research and experience. You are under no obligation to purchase these in our office but we cannot guarantee a similar quality from an outside source.

(initial)

Refunds will be given to any supplement that is unopened and returned within 14 days of purchase.

(initial)

ANY QUESTIONS I HAVE HAD REGARDING THE CARE IHHC PROVIDES HAS BEEN ANSWERED TO MY SATISFACTION PRIOR TO MY SIGNING THIS CONSENT FORM. I HAVE MADE MY DECISION VOLUNTARILY AND FREELY. BY SIGNING THIS DOCUMENT BELOW, AND INITIALING THE ABOVE STATEMENTS, I ACKNOWLEDGE I HAVE READ AND AGREE TO ALL OF THE ABOVE STATEMENTS.

Patient Name

Signed

Date

DEMOGRAPHIC PROFILE

Please complete to the best of your knowledge and return to our clinic so that we can schedule your initial appointment.

Today's date: _____

Legal Name: _____ Preferred Name: _____

Date of birth: _____ Sex: _____ Ht: _____ Wt: _____

Address: _____ City: _____ State: _____ Zip: _____

I wish to be contacted in the following manner (check all that is acceptable):

Cell Phone: _____ Check if we may leave a detailed message (test, results, billing, etc.)

Home Phone: _____ Check if we may leave a detailed message (test, results, billing, etc.)

Work Phone: _____ Check if we may leave a detailed message (test, results, billing, etc.)

My Email Address: _____

(By providing your e-mail address, you are giving your consent for future email communication from Integrative Health and Hormone Clinic. They may use this email through Constant Contact to send you email newsletters, promotions and discounts, and for marketing their events. You may request to have your email address removed from this list at any time.)

Legal Guardian (if applicable): _____ Relationship to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Name of Insurance: _____

Policy Holders Name: _____ Insurance Policy / Card # _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Alternative Providers (i.e. Chiropractor): _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Please list your race: White Asian Black or African American American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander Other Unreported/Refused to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Language Preference: English Other _____

Employment Status: Employed Not Employed Retired Occupation: _____

COMPREHENSIVE HEALTH INFORMATION

Referring Provider (if applicable): _____ Phone: _____ Fax: _____

How did you hear about us? _____

(If recommended by a current patient, please state who so we can send them a token of our appreciation.)

History of Present Illness (HPI)

When listing your history below, please prioritize and score their severity on a scale of 0-10 with 0 being non-bothersome and 10 being the worst imaginable. We may not have time to discuss everything in the first visit so prioritizing will assist us in addressing your most important issues during your initial visit.

	Description	Score	When did this start?
	Example: Hot Flashes	5	4 Months ago in May of 2010
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Is there anything that makes these problems better or worse?

Past Medical History:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Bladder tumor | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> BPH | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer
Type? _____ | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Celiac | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cysts (ovarian) | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Falls | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> PCOS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Prolapse vaginal | <input type="checkbox"/> Prostate issues | <input type="checkbox"/> Pulmonary emboli | <input type="checkbox"/> Renal disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Skin sensitivities | <input type="checkbox"/> Spinal cord injury | <input type="checkbox"/> STDs | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Vascular problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Urinary Infection | <input type="checkbox"/> Other _____ | |

Past Surgical History:

- | | | | | |
|---|--------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Bladder suspension | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> C-section | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Cardiac related |
| <input type="checkbox"/> Polyps | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Ovaries removed |
| <input type="checkbox"/> Other _____ | | | | |

Immunization History:

- | | | | | |
|--|---|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus, Year ____ | <input type="checkbox"/> MMR | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Influenza, Year ____ | <input type="checkbox"/> Gardasil | <input type="checkbox"/> BCG for TB | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Pneumonia,
Year ____ | <input type="checkbox"/> I prefer to not be
vaccinated | | | |

Environmental Allergies: _____

Food Allergies: _____

Drug Allergies _____

Please list an example of what you eat:

Breakfast _____

Lunch _____

Dinner _____

How many ounces of water do you drink daily? _____

Current Medications:

Medication	Dosage	Frequency	Who prescribed it?

For women, do you currently have an intrauterine device (IUD)? Yes No

Current Nutritional / Herbal Supplements: *Please bring supplements or a copy of the Ingredients to your visit*

Supplement	Dosage	Frequency	Who prescribed it?

Social History:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Smoke – Packs per day? _____ | <input type="checkbox"/> Caffeine – Times per day? _____ | <input type="checkbox"/> Exercise __x/week | <input type="checkbox"/> Employed |
| <input type="checkbox"/> History of smoking, date quit: _____ | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Amalgam, silver, or gold fillings | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Live alone | <input type="checkbox"/> Metal dental fillings removed? | <input type="checkbox"/> Occupational exposures |
| <input type="checkbox"/> Other drugs | <input type="checkbox"/> Married | | <input type="checkbox"/> Disabled |
| | <input type="checkbox"/> Sleep – Hours per night? _____ | | |

How were you delivered as a baby? Vaginal Delivery Cesarean Delivery

Were you breastfed as a child for over 6 months? Yes No

Have you taken numerous rounds of antibiotics in your life? Yes No

If so, for what? _____ For how long? _____

Have you had past exposure to water damaged buildings containing mold? Yes No Not Sure

Do you have current exposure to water damaged buildings containing mold? Yes No

How would you rank your stress from 0-10 with 10 ranking the highest? _____

Do you have history of any significant tick/bug bites? Yes No

Are you interested in IV Nutritional therapy? Yes No

Health Promotion/Screenings:

Have you had any of these in the past year?

- Vision check Dental Visit Yearly Exams Pap Mammogram

In the past 10 years?

- Bone Density Scan, Year _____ Colonoscopy, Year _____ EKG, Year _____
 Last lab work, Year _____ Perform breast self-exams Perform testicular self-exams

REVIEW OF SYSTEMS

Check all that apply.

Constitutional Fevers

- Hot flashes Fevers Night sweats Chills Fatigue
 Problems falling asleep Problems staying asleep Weight loss Weight gain
 Appetite change

Head/Eyes

- Contact lenses Glasses Vision loss Excessive tears Dry eyes
 Irritation Itching Blurring Double vision Discharge
 Light sensitivity

Ears, Nose, Throat

- Otagia-ear pain Otorrhea-drainage Hearing loss Ringing in ears Nasal polyps
 Nose bleed Sinus tenderness Congestion Postnasal drip Neck stiffness
 Hoarseness Sore throat Issues swallowing Dentures Mouth sores
 Bleeding gums

Cardiac

- Chest pain Palpitations Irregular beat Murmur Fainting
 History of Rheumatic Fever Edema (swelling) Shortness of breath with activity

Vascular

- Varicose Veins Claudication Raynaud's

Respiratory

- Cough Cough produces mucous Color of mucous _____ Amount of mucous _____
 Wheezing Shortness of Breath Wear oxygen Wear BI/CPAP

Gastrointestinal

- | | | | | |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Changes in bowel pattern | <input type="checkbox"/> Epigastric pain | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Flatulence |
| <input type="checkbox"/> Pain right upper | <input type="checkbox"/> Pain right lower | <input type="checkbox"/> Pain left upper | <input type="checkbox"/> Pain left lower | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Reflux | <input type="checkbox"/> Hernia | |

Genitourinary

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Hesitancy | <input type="checkbox"/> Frequency | <input type="checkbox"/> Urgency | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> #Urinations overnight, _____ | <input type="checkbox"/> Leakage of urine | | |

Musculoskeletal

- | | | | | |
|---|--------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Muscle Stiffness | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Limited ROM | |

Dermatology

- | | | | | |
|--------------------------------|-------------------------------------|---|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Birthmarks | <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Scars | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Suspicious lesions | <input type="checkbox"/> Mole Changes | |

Neurological

- | | | | | |
|-------------------------------------|------------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Head Spinning |
| <input type="checkbox"/> Nerve Pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tremor | <input type="checkbox"/> Memory loss | |

Endocrine

- | | | | | |
|---|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Hair changes | <input type="checkbox"/> Nail changes |
| <input type="checkbox"/> Goiter | | | | |

Hematology

- | | |
|--|--|
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Swollen lymph nodes |
|--|--|

Psych: How would you describe your mood?

- | | | | | |
|-----------------------------------|------------------------------------|----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pleasant | <input type="checkbox"/> Depressed | <input type="checkbox"/> Anxious | <input type="checkbox"/> Panic easily | <input type="checkbox"/> PTSD |
|-----------------------------------|------------------------------------|----------------------------------|---------------------------------------|-------------------------------|

Pain

If you have pain, what is the location of your pain? _____

On a scale of 0-10 with 10 being the worst pain imaginable and 0 being no pain, rank your pain: _____

What is the frequency of your pain?

- | | | | | |
|----------------------------------|------------------------------------|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> No pain | <input type="checkbox"/> Sometimes | <input type="checkbox"/> 50% of the time | <input type="checkbox"/> Frequently | <input type="checkbox"/> Constant |
|----------------------------------|------------------------------------|--|-------------------------------------|-----------------------------------|

Female

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Painful cycles | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Abnormal mammogram |
| <input type="checkbox"/> Pregnancy # ____ | <input type="checkbox"/> Miscarriage# ____ | <input type="checkbox"/> On birth control | <input type="checkbox"/> PMS symptoms in second half of cycle |
| <input type="checkbox"/> STDs | | | |

If currently taking birth control, which kind and how long have you been on it? _____

Have you had a hysterectomy? Yes No If yes, were your ovaries removed? _____

Have you taken hormone replacement therapy (HRT)? Yes No If yes, which kind? _____

Please check the routes that you have taken of HRT: Oral pills Patch Gel/cream Sublingual troche
 Vaginal ring

Your age when you began menopause _____ Year you began menopause _____

Are you interested in BioTe hormone pellet therapy? Yes No Unsure

Any other information we should know? _____

Male

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Testicular mass | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Penile sores | <input type="checkbox"/> Change in urine stream | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Penile discharge | | | |

Are you interested in BioTe hormone pellet therapy? Yes No Unsure

Any other information we should know? _____

FAMILY MEDICAL HISTORY

List any family relations that have had a history of the diseases below. For example, if your grandmother on your mother's side had diabetes, find diabetes in the Disease list and write "Maternal Grandmother".

Here is the list of the relatives that we need to know if they had any of these health problems:

Father	Paternal Grandfather	Paternal Grandmother
Great Paternal Grandfather	Great Paternal Grandmother	Paternal Uncle
Paternal Aunt	Paternal Male Cousin	Mother
Maternal Grandfather	Maternal Grandmother	Great Maternal Grandfather
Great Maternal Grandmother	Maternal Uncle	Maternal Aunt
Maternal Male Cousin	Brother	Sister
Child		

Diseases (write relative in the blank if they had the disease)

Alzheimer's _____	Anemia _____
Osteoarthritis _____	Asthma _____
Celiac Disease _____	Depression _____
Diabetes _____	Epilepsy _____
Glaucoma _____	Heart Disease _____
High Blood Pressure _____	Infertility _____
Liver Disease _____	Mental Illness _____
Osteoporosis _____	Stroke _____
Tuberculosis _____	Autoimmune Disease _____
Hypothyroid _____	Multiple Sclerosis _____
Cancer _____	Rheumatoid Arthritis _____
Breast Cancer _____	PCOS (Polycystic Ovary Syndrome) _____
Colon Cancer _____	Psoriasis _____
Ovarian Cancer _____	Prostate Cancer _____

Thank you for taking the time to fill out this form. Please return it to us at your earliest convenience so that we can schedule your initial appointment with one of our clinicians.