NAME: ____ DATE: _________________

ADDRESS: ____________________________CITY: ______________________STATE: ___________

ZIP: _____________ CELL #: ______________________ HOME #: ___________________________

SOC SECURITY #: ___________________________ DATE OF BIRTH: __________________________

DRIVERS LICENSE NUMBER: _______________________________________ STATE: _____________

EMAIL ADDRESS: ____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED ( ) UNDISCLOSED

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: ____

POLICY HOLDER'S NAME: ____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: ____

ID NUMBER (if different from social security number: _____________________________________

GROUP NUMBER:____

TYPE OF INSURANCE PLAN: ( ) HMO ( ) PPO ( ) MEDICAID ( ) MEDICARE ( ) OTHER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: ____

POLICY HOLDER'S NAME: ____

POLICY HOLDERS SOCIAL SECURITY NUMBER: ____

ID NUMBER (if different from social security number: _____________________________________

GROUP NUMBER:____

TYPE OF INSURANCE PLAN: ( ) HMO ( ) PPO ( ) MEDICAID ( ) MEDICARE ( ) OTHER

PATIENTS EMPLOYER: ____ WORK #: ____________________

BUSINESS ADDRESS: ____

CITY: ____ STATE: _____________ ZIP: ______________

EMPLOYER: ____ WORK #: ____________________________

EMERGENCY CONTACT: ______________________________________ PHONE: _____________________

RELATIONSHIP TO PATIENT: ____________________________ DATE OF BIRTH: _____________________

ADDRESS: ____

CONTACT #: ____ ( ) CELL ( ) HOME

PATIENT SIGNATURE: ____ DATE: _________________

HOW DID YOU HEAR ABOUT US? (Radio Station, TV Commercial, Facebook, Twitter, Friend,Other)____

WHOM MAY WE THANK FOR REFERRING YOU? ____

Patient Name: _________________________ DOB: ________________ Date: ______________

Occupation: ____

Primary Care Doctor (PCP): ___________________________ Phone number: ______________

Pharmacy Number: _________________________ Date of last physical exam: _____________

AXIS REJUVENATION

Personal Health History

Please circle 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 Cots	Edema
	Hypertension	Irregular Heartbeat	Congestive Heart Failure
Respiratroy	Sleep Apnea	Shortness of Breath	Asthma/ COPD
	Bronchitis	Pneumonia	Allergies
Gastrointestinal	Lactose Intolerance	Gall Bladder	Gall Stones
	Chronic Diarrhea	Chronic Constipation	
Genitourinary	Prostate Cancer	Prostate Cancer in Family	Overactive Bladder
	Painful Urination	Decreased Urinary Force	ON/OFF Urine Flow
	Enlarged Prostate	Blood in Urine	Kidney/Bladder History
Infection	Kidney/Bladder	Liver	Any other
Psychiatric	History of Depression	Personality Disorder	Any other

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers. Please make sure, to include any anti-anxiety or anti-depressant medications.

Drug Name ______________________________ Dosage __________ Frequency ______________

Taken for ____

AXIS REJUVENATION

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: _____ Sedentary (No exercise) _____ Mild exercise _____ 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 in order 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

Are you interested in quitting tobacco? ____

Illicit drug use: ____Yes Explain ____ ____No

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Daytime sleepiness ___ Yes ___No

Decreased concentration ____ Yes ____No

Decreased Energy ____Yes ____No

Decreasing muscle mass ____Yes ____No

Depression ____Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Diminished sex drive ____Yes ____No

Erectile dysfunction ____Yes ____No

Frequent joint/muscle pains ____Yes ____No

Height decrease ____Yes ____No

Increasing fatigue ____Yes ____No

Moodiness ____Yes _____No

Poor sleeping habits ____Yes ____No

Trouble losing weight ____Yes ____No

I have had testosterone checked previously ____Yes ____No

If yes when: ________________ Type: __________________ Usage: ______________

I Hereby also declare that I will not be attending or starting any military basic/advanced individual training (AIT) school while I am a patient of Axis Rejuvenation, LLC.

Patient Name (Print) ____DOB: ______________

Signature: ____Date: ______________