Men's Intake Form

Name: ____ Date: ____________________________

Address: ______________________________________ City: _________________ State: ___________

Zip: _____________ Cell #: ___________________________ Home #: __________________________

Social Security#: ___________________________ Date of Birth: ______________________________

Driver's License Number: ____ State: _____________

Email Address: ____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( )Widowed ( ) Separated ( ) Undisclosed

Patients Employer: ____ Work#: _____________________

Business Address: ____

City: _____________________________________ State: ____________________ Zip: ______________

Occupation: ____

Primary Insurance:___________________________________ Subscriber ID: __________________

Policy Holder Name: ____

Policy#: _____________________________________ Group#: ___________________________________

Secondary Insurance:_________________________________ Subscriber ID: __________________

Policy Holder Name: ____

Policy#: _____________________________________ Group#: ___________________________________

Emergency Contact: _______________________________________ Phone: ____________________________

Relationship to Patient: _____________________________________ Date of Birth: _____________________

Address: ____

How did you hear about us? (Radio Station, TV Commercial, Facebook, Twitter, Instagram, Friend, Other)

____

Whom may we thank for referring you? ____

Patient Signature: ____ Date: _________________________

Patient Name: ___________________________________ DOB: ___________________ Date: _______________

Primary Care Doctor (PCP): ____________________________________ Phone#: _________________________

Pharmacy#: _____________________________________ Date of Last Exam: _____________________________

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

Medication Name: ____________________________ Dosage: __________________ Frequency: _______________

Taken for: ____

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Taken for: ____

Medication Name: ____________________________ Dosage: __________________ Frequency: _______________

Taken for: ____

Allergies: Please circle (Y) (N) (No Known Allergies) If yes, list Allergies and Reactions

____

____

____

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)

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____

____

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) Please circle one.

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire:

Alcohol: Yes or No If Yes, number of drinks per week: ________________________________

Tobacco: Yes or No If Yes, Cigarettes Cigars Chew How many/much: _______________

Are you interested in quitting tobacco? ____

Illicit drug use: Yes or No If Yes, explain ____

Questionnaire:

Daytime Sleepiness: Yes______ No______

Decreased Energy: Yes______ No______

Depression: Yes______ No______

Memory Loss: Yes______ No______

Mood Swings: Yes______ No______

Height Decrease: Yes______ No______

Poor Sleep Habits: Yes______ No______

Decreased Concentration: Yes______ No______

Decreased Muscle Mass: Yes______ No______

Difficulty Learning New Things: Yes______ No______

Diminished Sex Drive: Yes______ No______

Erectile Dysfunction: Yes______ No______

Increasing Fatigue: 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: _________________________