Summit Male Medical Center, LLC

Patient Profile Sheet

Date: _____

Last Name: _____ First Name: _____

Address: _____ City: _____State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

What is the best # to reach you at? ___Cell ___Home ___Work May we leave a message? ___Yes ___No

Age: _____ Date of Birth: _____

Occupation: _____

Employer:_____

Email address: _____

*May we contact you via email? YES NO

Medical Questionnaire

(Please circle yes or no)

Concerns with Erectile Dysfunction (ED)

Difficulties getting an erection	yes	no	If yes, how long (months/years) _____
Difficulties maintaining an erection	yes	no	If yes, how long (months/years) _____
Premature Ejaculation (PE)	yes	no	____under 2 minutes ____2-5 minutes ____5-10 minutes
Difficulty attaining orgasm	yes	no	If yes, how long (months/years) _____
Low semen volume (or none)	yes	no	If yes, how long (months/years) _____
Irregular curve of penis (Peyronie's)	yes	no	If yes, how long (months/years) _____

Strength of erection 0% 10% 25% 50% 75% 100% (Note: 75% = just firm enough to penetrate)

Please describe your main concerns: _____

Have you used any of these ED treatments/medications?

	Y / N	In Last 48 hrs?	When used (date range)	Describe Results
Viagra	_____	_____	_____	_____
Cialis	_____	_____	_____	_____
Levitra	_____	_____	_____	_____
Trimix Inj	_____	_____	_____	_____
Muse	_____	_____	_____	_____
Caverject	_____	_____	_____	_____
Vacuum Pump	_____	_____	_____	_____

Other methods tried: _____

Concerns with Possible Low Testosterone

Low libido or low sexual desire	yes	no	If yes, how long (months/years) _____
Low energy/ fatigue	yes	no	If yes, how long (months/years) _____
Low mental focus or concentration	yes	no	If yes, how long (months/years) _____
Reduced muscle mass	yes	no	If yes, how long (months/years) _____

Have you been diagnosed with low testosterone?	yes	no	If yes, when _____
Have you used any testosterone meds in the past?	yes	no	If yes, What type? _____ Last used _____

Medical History

Diabetes	Yes	No	High Cholesterol	Yes	No
High Blood Pressure	Yes	No	Coronary Heart Disease	Yes	No
Heart Attack	Yes	No	Blocked Artery	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Prostate Cancer	Yes	No	Peyronie's Disease	Yes	No
Hypogonadism (Low-T)	Yes	No	Hypothyroid	Yes	No
Bowel Problems	Yes	No	Enlarged Prostate (BPH)	Yes	No
Multiple Sclerosis	Yes	No	Parkinson's disease	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Sexually Transmitted	Yes	No	HIV Infection/ Aids	Yes	No
Blood Transfusion	Yes	No	Major Depression	Yes	No
Tuberculosis	Yes	No	Bleeding Disorder	Yes	No

Other_____

Current medications (Please list both prescriptions and over-the-counter medication as well as strength and frequency)

_____

_____

_____

Surgical History			Year				Year
Heart	Yes	No	_____	Blocked Artery (stent)	Yes	No	_____
Prostate	Yes	No	_____	Penis	Yes	No	_____
Bowel	Yes	No	_____	Bladder	Yes	No	_____
Hernia	Yes	No	_____	Head	Yes	No	_____
Vasectomy	Yes	No	_____	Spine	Yes	No	_____

Other_____

Previous Urology Problems

Kidneys	Yes	No	Penis	Yes	No
Bladder	Yes	No	Testicles	Yes	No
Prostate	Yes	No	Urine	Yes	No

Explain: _____

Other Injuries

Head	Yes	No	Back	Yes	No
Pelvis	Yes	No	Penis	Yes	No

Other: _____

Family History (father, grandfather, brothers)

Diabetes	Yes	No	Heart Attack (MI)	Yes	No
Prostate Cancer	Yes	No	High Blood Pressure	Yes	No

Other Significant Family History _____

Medication and Other Allergies

Are you Allergic to any Prescription Medications? Yes No If Yes, what medications _____

Please describe your reaction _____

Are you Allergic to Nuts/Peanuts? Yes No

Do you have any other significant Food Allergies? If yes, please list _____

Do you have Seasonal Allergies Yes No

Do you ever take Sudafed (Pseudoephedrine) for your seasonal allergies Yes No

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Social History:

Do You Smoke? __Yes __No How Many Packs Per Day? _____
Do you consume alcoholic beverages: ____ Y ___ N _____# drinks per week
Marital Status: ___Single ___Married __Divorced ___Separated ___Widowed
Physical Activity: ___Inactive ___Light ___Moderate ___Heavy

Please list current physicians:

	Name	Phone	Specialty	Last Visit
Family Physician	_____	_____	_____	_____
Specialist	_____	_____	_____	_____

How did you hear about Summit Male Medical Center?

(Choose all that apply)

→ Radio:

___ 620 AM KTAR Sports
___ 92.3 FM KTAR Talk Radio
___ 94.5 FM KOOL
___ 104.3FM Mega KAJM
___ 93.3 FM KDKB Rocks AZ
___ 1260 AM NBC Talk Radio
___ 910 AM XTRA Sports KGME
___ 550 AM KFYI Newstalk
___ 96.1 KLPX Tucson – Classic Rock
___ 102.5 KNIX Country
___ My 103.9 KEXX
___ 96.3 Real Country
___ 98 KUPD Real Rock
___ 97.5 HOT Hits Now
___ 790 AM Tucson KNST – News, Sports, Talk
___ 98.7 The Peak
___ Not sure/Can't remember

→ Newspaper: Arizona Republic _____
→ Mailbox Mailer _____

→ Television: ABC12 _____

→ Friend: Whom can we thank? _____

→ Other:_____

The following to be completed by Physician or staff member

Reviewed by: _____ M.D. / N.M.D

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____ Date : _____

Permission to share Your Protected Health Information:

By signing below, you authorize Summit Male Medical Center and it's representatives to share your protected health information with the person identified below. Your authorization is completely voluntary and can be revoked, in writing, at any time.

Name of person you wish to share information with: _____

Relationship to Patient: _____

Patient Signature: _____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____

Reason: _____