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Male New Patient Registration

Last Name_____ First Name_____ M_____

Date of Birth_____ Sex ☐M ☐F Marital Status_____ SSN_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Race_____ Ethnicity Hispanic Non-Hispanic

Email_____ Occupation_____

Primary Care Provider_____ Referring Provider_____

Primary Pharmacy_____

Address_____

How did you hear about us? ☐BILLBOARD ☐FAMILY ☐FRIEND ☐PROVIDER ☐INSURANCE ☐INTERNET SEARCH ☐SOCIAL MEDIA ☐WALK-IN ☐OTHER_____

INSURANCE INFORMATION

IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY BELOW

Primary Insurance_____	Secondary Insurance_____
Individual ID # _____	Individual ID # _____
Group_____	Group_____
Policyholder_____	Policyholder_____
Relationship to Patient_____	Relationship to Patient_____
DOB____/____/ _____ SSN ____-____-_____	DOB____/____/ _____ SSN ____-____-_____

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Cell Phone_____ Work Phone _____

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Patient Signature _____ Date_____ Time_____

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Reason for visit_____

Preventative Health

Immunization	Date Performed	
Influenza Vaccination		
Prevnar (1st Pneumonia Shot)		
Pneumovax (2nd Pneumonia Shot)		
Tetanus Vaccination		
TDAP		
Zostavax (Shingles Vaccine)		
Covid Vaccine		
Gardasil		

Screening Test	Date Performed	Results (Normal/Abnormal)
Colonoscopy		
Mammogram		
PAP		
PSA (prostate)		
Chest X-Ray		
Screening Chest CT (Lung Scan)		
Dexa Scan (Bone Scan)		
Annual Lab (in the past year)		

ALLERGIES

Please list all food and drug allergies:

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PAST MEDICAL HISTORY

PLEASE MARK ANY CURRENT OR PREVIOUS ILLNESSES OR HEATH PROBLEMS.

- ☐ ANXIETY
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASBESTOS EXPOSURE
- ☐ ASTHMA
- ☐ BIPOLAR DISORDER
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ COPD/EMPHYSEMA
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DEGENERATIVE JOINT DISEASE
- ☐ DIABETES MELLITUS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART RHYTHM PROBLEM
- ☐ HEPATITIS
- ☐ HIGH CHOLESTEROL
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV
- ☐ KIDNEY DISEASE
- ☐ LUPUS
- ☐ RHEUMATOID ARTHRITIS
- ☐ PARKINSON'S DISEASE
- ☐ SEIZURE DISORDER
- ☐ SCHIZOPHRENIA
- ☐ SLEEP APNEA
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS (POSITIVE PPD)
- ☐ ULCERS
- ☐ CHRONIC PAIN related to _____
- ☐ OTHER: _____

SURGICAL HISTORY/MAJOR DIAGNOSTIC PROCEDURES

- ☐ APPENDECTOMY
- ☐ BACK SURGERY
- ☐ BARIATRIC (WEIGHT REDUCTION)
- ☐ BREAST AUGMENTATION
- ☐ BREAST CANCER REMOVAL
- ☐ C-SECTION
- ☐ GALLBLADDER
- ☐ LUNG BIOPSY
- ☐ LUNG RESECTION
- ☐ HEART CATHETERIAZATION
- ☐ HEART BYPASS SURGERY
- ☐ PROSTATE SURGERY
- ☐ HYSTERECTOMY
- ☐ SKIN CANCER REMOVAL

  TYPE_____
- ☐ TONSILLECTOMY
- ☐ TUBAL LIGATION
- ☐ TUMOR REMOVAL
- ☐ VASECTOMY
- ☐ OTHER:_____

  _____

  _____

  _____

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HOSPITALIZATIONS/ER VISITS

MEDICATIONS

Please attach a list or list all medications you are currently taking below, including over the counter and herbal remedies. Please include dosage and number of times a day the medicine is taken if known.

MEDICATION NAME	DOSAGE (mg, cc, etc)	FREQUENCY (how often)

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FAMILY HISTORY

Are you adopted? _____

	Father	Mother	Siblings	Paternal GF	Paternal GM	Maternal GF	Maternal GM
LIVING							
DECEASED							
DIABETES							
HYPERTENSION							
HEART DISEASE							
MENTAL ILLNESS							
CANCER (TYPE?)							
STROKE							
THYROID DISEASE							
HIGH CHOLESTEROL							
ASTHMA							
COPD/EMPHYSEMA							
BLOOD CLOTS							
TUBERCULOSIS							
HEADACHES							
SEIZURES							
OTHER (SPECIFY)							
UNKNOWN							

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SOCIAL HISTORY

Tobacco Use:

____ Never Smoked
____ Former Smoker
How long has it been since you quit?
___ Less than 1 year ___ 1-5 years ___ 5-10 years ___ 10-20 years ___ 20+ years
____ Current Smoker
If yes, how often do you smoke?
____ Daily ____ Frequently ____ Rarely
How many cigarettes do you smoke in 24 hours?
____ 5 or less ____ 6-10 ____ 11-20 ____ 21-30 ____ 31+
Do you use other forms of tobacco?
____ Cigar ____Pipe ____Chewing Tobacco ____Vapor

Medical Marijuana Use:
____ Yes ____ No

Recreational Drug Use:
____None ____Marijuana ____Cocaine ____Heroin ____Prescription Pain Pills
____Methamphetamines ____ Other

Alcohol Use:
How often do you drink? _____

Caffeine:
____ Coffee ____ Soda ____ Energy Drinks ____ Tea How many daily? _____

Children:
____ Yes ____ No
If yes, how many? _____
Have you completed your family?
____ Yes ____ No

Exercise:
____ Daily ____Occasionally ____ Rarely ___ Never
What kind of exercise? _____
General Stress Level:
____ Low _____ Moderate _____ High

Is a blood transfusion agreeable to in an emergency? History of a blood transfusion?
____ Yes ____ No
Advance Directive:
_____ Yes _____ No

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No Show and/or Cancellation Policy

Failure to CANCEL within a 24-hour time prior to your appointment time will result in a $35 fee.
Failure to NOT SHOW for an appointment will result in a $35 no show fee.

_____ _____
Patient Signature Date

Laboratory

We ask that each patient know his/her insurance benefits, including your lab benefits, prior to your scheduled appointment time.
You will need to know how much your individual lab policy covers and which lab your insurance prefers you go to (DLO or Lab Corp). You have the option to send your lab through your insurance or you can choose to do self-pay through us. If you choose to send through your insurance, you will be responsible for any co-insurance or deductible that applies. You will not receive a bill for lab work from Choctaw Women`s Clinic for your lab work, it will come from the lab itself.
If you choose self-pay, you pay us at date of service and you will not receive a bill from the labs.
Circle one: Insurance or Self-pay

_____ _____
Patient Signature Date

Medical Release Form

I, _____ hereby **DECLINE** the Provider and staff of Elite Wellness permission to release information concerning my health and well-being.
I, _____ hereby authorize the Provider and staff of Elite Wellness permission to release information concerning my health and well-being to the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

The following information may be given to the above individuals: (please check all you agree to):
( ) Any other information (No limitation) includes all communication.
( ) Appointment Time ( ) Test/Lab Results ( ) Procedures ( ) Medications

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I understand that this organization originates and maintains health records describing my health history, symptoms, diagnoses, examinations, past/current/future treatments and test results as well as financial information pertaining to my account. I acknowledge that I have been provided with Full Disclosure of their Notice of Privacy Practices and I consent to the use and disclosure of my own or persons from whom I am responsible (i.e. minors) Financial and Health Information for any reason that Choctaw Women's Clinic may require to carry out Health care operations to or for me and/or for persons whom I am responsible.

Patient Signature: _____ Date: _____
(Parent/Guardian Signature if patient is a minor.)

Witness Signature: _____ Date: _____

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Address and Contact Information

Name: _____ Date of Birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80