

# Male Initial Health Assessment & Consents



## Patient Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Home Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

May we leave detailed messages at this phone number?  Yes  No

May we send text messages regarding appointments and/or treatment?  Yes  No

Primary Care Provider: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

In the event that we are unable to contact you by the means provided above, please designate someone that you give us permission to talk to about your treatment. By giving the information below, you consent to us speaking with the designated individual.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

We are so glad that you are here! Would you mind sharing how you heard about us?

Please briefly describe the main reasons that you are here today:

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# Male Initial Health Assessment & Consents



## Male Health Assessment Questionnaire

Please mark the appropriate box for each symptom:

Symptoms	None	Mild	Moderate	Severe	Very Severe
Physical exhaustion (fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems (difficulty falling asleep or sleeping through the night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (feeling overwhelmed feeling panicky, or feeling nervous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in drive or interest (loss of “zest for life”, feeling sad or down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and/or muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory (concentration, finding the right word, or retaining information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual desire or performance (reduced or diminished)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile changes (weaker erections, loss of morning erections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculations (infrequent or absent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating ( night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss (rapid or thinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling cold all the time, having cold hands and/or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or migraines (increase in frequency or intensity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight (difficulty losing weight despite diet and exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased frequency or urgency)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Lifestyle Assessment:*

**1. Weight & Lifestyle History**

- How long have you been trying to lose weight? \_\_\_\_\_
- Previous weight loss methods (diets, medications, programs):

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- What worked? \_\_\_\_\_
- What did not work? \_\_\_\_\_

**Biggest challenges with weight loss:**

- |   |   |
|---|---|
| <input type="checkbox"/> Hunger           | <input type="checkbox"/> Lack of time   |
| <input type="checkbox"/> Cravings         | <input type="checkbox"/> Low energy     |
| <input type="checkbox"/> Emotional eating | <input type="checkbox"/> Medical issues |
|   | <input type="checkbox"/> Other: _____   |

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**2. Current Diet Assessment: Typical Daily Intake (24-Hour Recall):**

**Breakfast:**

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**Mid-morning snack:**

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**Lunch:**

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**Afternoon snack:**

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**Dinner:**

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**Evening snack:**

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**Beverages (type & quantity):**

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**Do you have any food allergies or foods you don't like to eat:**

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**3. Additional Questions:**

- How many meals per day do you typically eat? \_\_\_\_\_
- Do you eat late at night?  Yes  No
- Frequency of eating out: \_\_\_\_\_ times/week
- Water intake: \_\_\_\_\_ oz/day

**Dietary Patterns:**

- High protein
  - High carbohydrate
  - High fat
  - Vegetarian/Vegan
  - Keto/Low-carb
  - Other: \_\_\_\_\_
- 

**4. Physical Activity**

**Current Exercise Routine:**

- Type(s) of exercise: \_\_\_\_\_
- Frequency (days/week): \_\_\_\_\_
- Duration per session: \_\_\_\_\_ minutes

**Activity Level:**

- Sedentary (little/no exercise)
- Lightly active (1–2 days/week)
- Moderately active (3–4 days/week)
- Very active (5+ days/week)

**Barriers to exercise:**

- Time
  - Motivation
  - Pain/injury
  - Access to facilities
  - Other: \_\_\_\_\_
- 

**5. Sleep Habits**

- Average hours of sleep per night: \_\_\_\_\_
- Bedtime: \_\_\_\_\_ Wake time: \_\_\_\_\_

**Sleep Quality:**

- Excellent
- Good

- Fair
- Poor

**Do you experience:**

- Difficulty falling asleep

- Frequent awakenings
- Snoring

- Daytime fatigue
- Diagnosed sleep apnea

## 6. Behavioral & Mental Health

- Do you eat in response to stress/emotions?  Yes  No
- Stress level (1–10): \_\_\_\_\_
- Mood:  Stable  Anxious  Depressed  Other: \_\_\_\_\_

### Support system:

- Strong  Moderate  Limited

## 7. GLP-1 Therapy Considerations

- Have you used GLP-1 medications before?  Yes  No  
If yes, which one(s): \_\_\_\_\_
- Any history of:
  - Pancreatitis
  - Gallbladder disease
  - Thyroid cancer or MEN2
  - Severe gastrointestinal disease

## 8. Goals & Expectations

- What are your primary goals with treatment?
  
- What would success look like in 3–6 months?

- Are you willing to:
  - Modify diet
  - Increase activity
  - Track food intake
  - Attend follow-ups

## Personal Health History

- Currently trying to conceive?  Yes  No
- Are you currently taking a 5-alpha reductase inhibitor (ex. Finasteride, dutasteride)?  Yes  No
- Are you currently taking a PDE-5 inhibitor (ex. Cialis, Viagra, etc)?  Yes  No
- Are you currently on any other testosterone boosting medication (ex. Clomid, HCG, etc.)?  Yes  No
- Are you currently using bioidentical hormone replacement or hormone replacement therapy?  
 Yes  No
  - If yes, select types of hormones:  Thyroid  Testosterone
  - List name and dosage: \_\_\_\_\_
- Are you currently taking a statin (ex. Rosuvastatin, atorvastatin, pravastatin, etc.)?  Yes  No
- Are you a smoker?  Yes  No If yes, how many cigarettes per day? \_\_\_\_\_
- Are you currently taking oral nitrates (ex. Isosorbide, nitroglycerine, etc.)?  Yes  No
- Do you have a history of snoring?  Yes  No Is it severe?  Yes  No
- Do you currently wear a CPAP or BiPAP machine?  Yes  No

## Personal Medical History:

### Please select all the apply:

#### **Fertility:**

- Want to maintain fertility

#### **Cardiovascular Conditions:**

- Heart Attack or Stroke (within the last 6 months)
- Tachycardia
- DVT or blood clot (within the last 6 months)
- Hypertension

- Hyperlipidemia
- Obstructive Sleep Apnea
- Take anticoagulant medication
- Atrial fibrillation

#### **Cancer:**

- Breast cancer or History of Breast Cancer
- Active prostate cancer or history of prostate cancer

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Thyroid cancer or History of Thyroid

Any other form of cancer?

Cancer

Basal Cell Carcinoma

## Personal Medical History continued:

### **Neurological Conditions:**

Epilepsy or Seizure Disorder

Depression/Anxiety

Psychiatric Conditions

Migraine with Aura

Meningioma

### **Endocrine and Metabolic:**

Diabetes Type 2 or Insulin Resistance

Hyperthyroid

Hypothyroid

Multiple endocrine neoplasia type 2

### **Autoimmune Conditions:**

Diabetes Type 1

Hashimoto's Thyroiditis

Grave's Disease

Rheumatoid Arthritis

Multiple Sclerosis

Systemic Lupus (Erythematosus)

Psoriasis

IBS (irritable bowel syndrome)

Crohn's Disease

Ulcerative Colitis

### **Organ Specific Conditions:**

Liver Disease or History of Liver Disease

Kidney Disease or History of Kidney Disease

LAM (Lymphangiomyomatosis)

Osteoporosis or Osteopenia

Prostate enlargement (BPH)

HIV

Hepatitis

Hemochromatosis

Pancreatitis or History of Pancreatitis

History of Gall Bladder Disease

Polycythemia Vera (PV)

## Medications & Allergies:

- Do you have any medication allergies?  Yes  No
  - If yes, please list: \_\_\_\_\_
- Do you have an allergy to latex?  Yes  No
- Do you have allergies or intolerance to adhesives (ex band aids etc.)?  Yes  No
- Please list all medications that you are currently taking with the dose?  
 \_\_\_\_\_  
 \_\_\_\_\_

Family Member	Pancreatitis	Diabetes	Medullary Thyroid Cancer	Multiple Endocrine Neoplasia	Heart Disease	Breast Cancer	Osteoporosis	Alzheimer's/ Dementia	Deceased	Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# Male Initial Health Assessment & Consents



	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Symptoms & Concerns:

- Acne
- Erectile Dysfunction (ED)
- Decreased Libido
- Decreased Desire
- Inability to or Delayed Orgasm
- Weight Gain
- Decreased Muscle Mass
- Difficulty Sleeping
- Urinary Incontinence
- Dry or Flaking skin
- Lack of Energy (fatigue)
- Decreased Strength or Endurance
- Decreased Work Performance
- Frequent Urinary Tract Infections
- Brittle Nails
- Thinning Eyebrows
- Cold Hands and Feet
- Mind Racing at Bedtime
- Eating When Stressed
- Mood Swings
- Gynecomastia
- Abdominal Obesity

Is there any other pertinent information that you would like to share with your provider: \_\_\_\_\_

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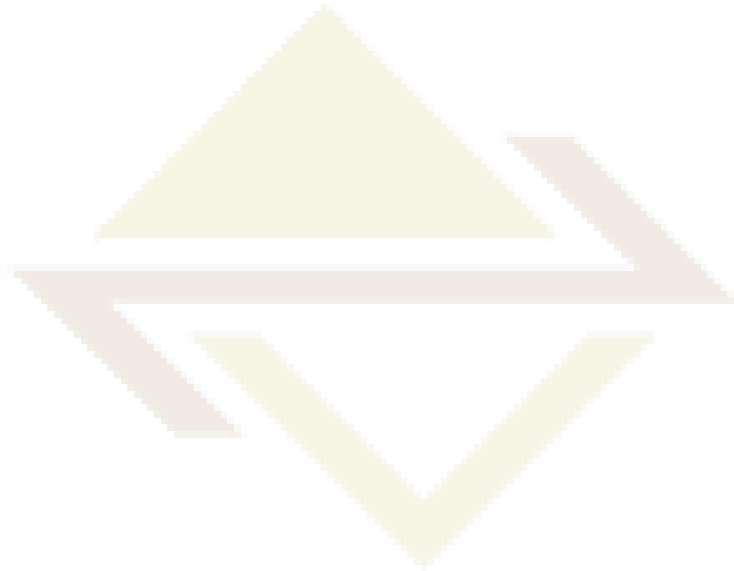
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NORTHVIEW  
MEDICAL

**NORTHVIEW MEDICAL CONSENT TO TREAT**

I hereby request and consent to the performance of examinations, lab draws, and insertion of pellets or other procedures in relation to BioTe, where warranted, on me (or on the patient named below, for whom I am legally responsible for) by the practitioner named below and/or other licensed doctors who now or in the future work at the clinic or office listed below:

Amanda Tanner, CNM-APRN

I have had an opportunity to discuss with the practitioner named the nature and purpose of procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine there are some risks to treatment I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. The practitioner named above has additionally explained the risks associated with my refusal of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Informed Consent for Conservative Care**

To the patient: You have a right to be informed about your condition, the recommended treatment, and the potentiality of any risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

\_\_\_ I understand that the Provider will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner.

\_\_\_ I understand that the Provider may be prescribing medications but will not be giving any advice about medications that I am currently taking. All medication advice is referred to your pharmacist and primary provider.

\_\_\_ I understand that there are some risks to the insertion of pellets including, but not limited to: increased symptoms and pain, no improvement of symptoms or pain.

I have read, or have had read to me, the above consent. By signing below, I consent to the initial visit. I intend this consent form to cover the entire course of my treatment for my current condition.

To be completed by the patient:

To be completed by the patient’s representative (if applicable):

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Patient’s Name

\_\_\_\_\_  
Signature

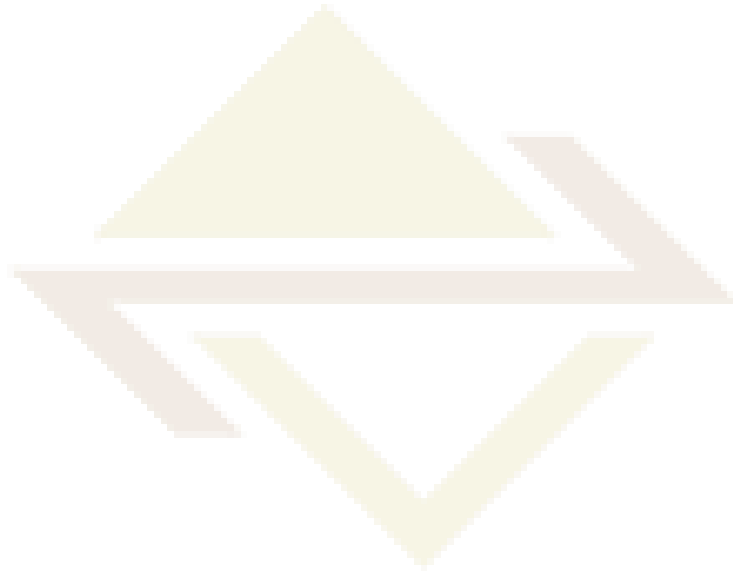
\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Rep’s Signature / Relationship

\_\_\_\_\_  
Witness/Date

\_\_\_\_\_  
Date Signed



NORTHVIEW  
MEDICAL

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance, health plan, or medical benefits I have), I am ultimately responsible to pay Northview Medical Clinic, as well as all licensed professionals, employees, employers, representatives, and agents thereof; as well as all laboratories, pharmacies, clinics, hospitals, and equipment suppliers used by or referred by Northview Medical Clinic or by any of the forgoing (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, equipment, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. It is also my intention that Healthcare Provider shall possess any and all anti-retaliation protections that I may have under 29 U.S.C. § 1140 whenever Healthcare Provider is exercising my rights or acting on my behalf, or as my assignee, in anyway whatsoever.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing, and in such case, can only be revoked for future services, test, etc. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Witness/Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

If applicable:

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Patient's Name

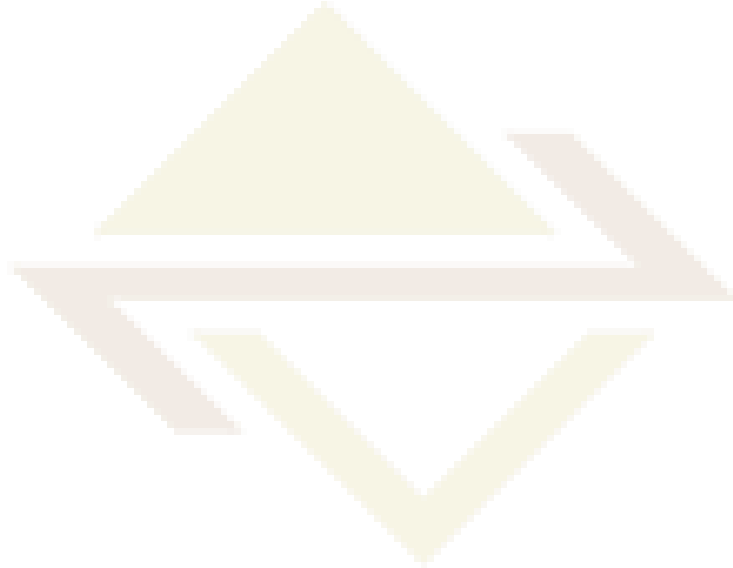
# Male Initial Health Assessment & Consents



Name of Representative

\_\_\_\_\_  
Rep's Signature / Relationship

\_\_\_\_\_  
Date Signed



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