MultiCare Plus

MAK Healthcare, PC

225 Erdman St

Bangor PA, 18013

Personal Data		
Name	Date	Social Security #
Address	City State	Zip
Home phone	Work phone/Cell phone	Date of birth
Employer	Emergency Contact	Phone
Email	Marital Status Married Single	

Primary Care Physician		
Name	Phone/Fax Number	
Address	City State	Zip
Pharmacy Name	Phone/Fax Number	

Who can we thank for your referral to our office for pellets therapy? _____

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

Past Surgical History

Date	Surgery

Medications: Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, prostate, lung, skin, blood), etc. If a member is deceased, please list age at death and cause of death if known.

Relationship	Age	Medical problem / Cause of death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Please remember this information is strictly confidential and will be used only to address you symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No • If yes, how many packs per day? _____ • How many total years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No • If yes, how many drinks and what kind (wine, beer, bourbon, etc.) do you have in an average week? _____.

Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? ☐ Yes ☐ No • If yes, what substance and how often_____.

Urological History

Date of last prostate exam? _____

Physician who performed? _____
Physician's Phone Number: _____.
Date of PSA blood work/? _____
Facility/Office where performed: _____
Facility/Office Phone Number: _____.

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have?		
Have you ever had an elevated PSA? If yes, what follow up did you have?		
Have you ever had a prostate biopsy?		

Do you have a history of any of the following **cancers**: ☐ Lung ☐ Breast ☐ Colon ☐ Prostate ☐ Skin ☐ Lymphoma ☐ Leukemia ☐ Other:

Have you been treated with any hormone replacement therapy?
If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

Low Libido ☐ Lack of Energy ☐ Decreased Strength / Endurance ☐ Lost Height ☐ Decreased Enjoyment of Life ☐ Sad or Grumpy ☐ Problem with Memory / Concentration ☐ Decreased Erections ☐ Decreased Ability to Play Sports ☐ Fall Asleep After Dinner ☐ Sleep Disturbances ☐ Recent Deterioration in Work Performance ☐ Decreased Muscle Mass ☐ Hair Loss

Adrenals Check which of these symptoms are troublesome and have persisted over time	
Cortisol Excess	**Cortisol Deficiency**
☐ Sleep Disturbances ☐ Bone Loss ☐ Fatigue ☐ Weight Gain -Waist ☐ Loss of Muscle Mass ☐ Thinning Skin ☐ Elevated Triglycerides ☐ Breast Cancer ☐ Irritable ☐ Anxious ☐ Memory ☐ Heart Palpitations ☐ Headaches ☐ Stress ☐ Cold Body Temperature ☐ Sugar Cravings ☐ Low Libido ☐ Hair Loss ☐ Increased Body Hair ☐ Acne ☐ Nervous	☐ Fatigue ☐ Sugar Craving ☐ Allergies ☐ Chemical Sensitivity ☐ Stress ☐ Cold Body Temperature ☐ Irritable ☐ Arthritis ☐ Heart Palpitations ☐ Aches/Pains

Thyroid Check which of these symptoms are troublesome and have persisted over time	
Thyroid Excess	**Thyroid Deficiency**
Heat Intolerance ☐ Voice has become horse Palpitations Weight Loss ☐ Tremors / Shakiness ☐ Diarrhea ☐ Nervousness / Anxious / Panic Attacks ☐ Muscle Weakness ☐ Difficulty Conceiving / Infertility ☐ Coarse Dry Skin ☐ Insomnia	☐ Cold Intolerance ☐ Constipation ☐ Fatigued / Weakness ☐ Unexplained Weight Gain ☐ Inability to Loose Weight ☐ Stress ☐ Cold Body Temperature ☐ Irritable ☐ Lack of Motivation ☐ Muscle Cramps ☐ Aches/Pains

System Review – Check the appropriate box for each question.			
Constitutional / ID / Oncology	**Yes**	**No**	**Not Sure**
Have you had unexplained weight loss?			
Do you have fever of chills?			
Do have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive of HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma, emphysema or Sleep Apnea			

System Review – Check the appropriate box for each question.

Cardiovascular	Yes	No	Not Sure
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Vascular disease or artery blockages/aneurysms?			
Have you been diagnosed with any heart condition? Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated bood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes:

Disclosure / Liability Waiver

MAK Healthcare. PC Bio-Identical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from MAK Healthcare, PC. And /or MultiCare Plus, its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

Print Name Date

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, mammogram, prostate examination, and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

Print Name Date