Byers Wellness Center-Male Patient Information

Welcome to Byers Wellness Center. We are excited to have you as one of our patients. In order for us to best serve you on your initial visit we ask that you complete this information and send it to us prior to your appointment time. You may fax this information to us at (770) 387-3425 or send via email to byerswellnesscenter@hotmail.com. If you have any questions, please don't hesitate to call us at (770) 387-3450.

General Patient Information

Patient's Name:		Date:
Address:		
City:	State:	Zip:
Date of Birth:	Social Security #:	
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Marital Status:		
Spouse's Name:		
Patient Employed By:		
Employer Address:		
How did you hear about us?		
In case of emergency, whom should we notify?		
Relationship to Patient?	Phone Number: ( )	

Testosterone levels begin to decline at 30 years of age, and the typical male's testosterone declines by approximately 10% per decade. This questionnaire is intended to help you inform your doctor of any symptoms you may be experiencing due to low testosterone levels. Together you can decide on a course of treatment—and begin discussing the things you need to know about your health.

PERSONAL HEALTH HISTORY/STATUS

Current Weight: ____________ **Height: _______**

Are you sexually active? ☐ Yes ☐ No

Age of first sexual contact? ☐ Yes ☐ No

Do you have a history of sexually transmitted diseases? If yes please list: ☐ Yes ☐ No

____

Have you had a sperm count analysis? ☐ Yes ☐ No
Date: ___________ Results: _____________

Have you had the mumps? ☐ Yes ☐ No
Date: _______________

Have you had Testicular cancer? ☐ Yes ☐ No
Date: _______________

Do you have prostate problems? ☐ Yes ☐ No
If yes, please describe: ____

Have you had blood in your urine? ☐ Yes ☐ No
If yes, when & treatment:____

Have you had any bladder or kidney problems? ☐ Yes ☐ No
If yes, when & treatment:____

Do you have erectile dysfunction? ☐ Yes ☐ No
If yes, please describe:____

Do You Suffer From:

☐ Fatique ☐ Decrease of Memory

☐ Decrease of energy level ☐ Decrease of sexual drive? ☐ Anxiety

☐ Irritability ☐ Mood Swings ☐ Migraines

How have you dealt with these symptoms?

____

____

____

Do you initiate intercourse? ☐ **Yes** ☐ **No**

Is intercourse satisfying? ☐ **Yes** ☐ **No**

Do you achieve orgasm? ☐ **Yes** ☐ **No**

Do you suffer from premature ejaculation? ☐ **Yes** ☐ **No**

How often you have intercourse?____

Is your sex drive the same as it was five years ago? ☐ **Yes** ☐ **No**

Describe:____

List any other sexual dysfunctions:

____

____

____

Have you experienced weight gain in the last one-two years? ☐ **Yes** ☐ **No**

If yes, please describe:____

Have you lost greater than 10 pounds in less than a month? ☐ **Yes** ☐ **No**

If yes, why?____

Are you HIV positive? ☐ **Yes** ☐ **No**

If yes, when?

Treatment:____

Have you ever been tested for AIDS? ☐ **Yes** ☐ **No**

Results:____

Have you fathered any children? ☐ **Yes** ☐ **No**

If yes, how many?____

Have you had your testosterone level taken: ☐ **Yes** ☐ **No**

List Current Medications and dosages including over the counter medications, prescriptions, natural supplementation and vitamins:

____

____

____

____

Sexual Orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual

PAST MEDICAL AND FAMILY HISTORY

Do you have diabetes? ☐ **Yes** ☐ **No**

Do you have/had hypertension? ☐ **Yes** ☐ **No**

Do you have heart disease? ☐ **Yes** ☐ **No**

Do you have a heart murmur? ☐ **Yes** ☐ **No**

Do you have/had kidney disease?	☐ Yes	☐ No
Have you ever been treated for psychiatric problems?	☐ Yes	☐ No
Have you ever had rheumatic fever?	☐ Yes	☐ No
Do you have mitral valve prolapsed?	☐ Yes	☐ No
Have you ever had a urinary tract infection?	☐ Yes	☐ No
Have you ever had hepatitis/liver disease?	☐ Yes	☐ No
Have you ever had varicosities/phlebitis?	☐ Yes	☐ No
Do you have any thyroid problems?	☐ Yes	☐ No
Have you had any major accidents?	☐ Yes	☐ No
Have you ever had any blood transfusions?	☐ Yes	☐ No
Do you have asthma/lung disease?	☐ Yes	☐ No
Do you have any drug allergies? If yes, please list: ______________________________	☐ Yes	☐ No
Do you have lupus?	☐ Yes	☐ No
Do you have arthritis?	☐ Yes	☐ No

Please list any surgeries and dates:
Please list any other operations/hospitalizations (include year & reason):
Please list any complications you have had from anesthesia?

Have you ever been anemic?	☐ Yes	☐ No
Have you had your cholesterol checked?	☐ Yes	☐ No
Date last checked? Was it normal:	☐ Yes	☐ No
Do you have an internist or family doctor? Please list name and phone number	☐ Yes	☐ No

____

____

____

SOCIAL HISTORY

Do you smoke cigarettes?' If yes, number per day? ____________ Number of years? ____________	☐ Yes	☐ No
Do you use street drugs?	☐ Yes	☐ No
Do you drink alcohol? If yes, how much per day? ______________________________	☐ Yes	☐ No

FAMILY HISTORY

Do you have a family history of breast cancer? If yes, whom?	☐ Yes	☐ No
Do you have a family history of colon cancer? If yes, whom?	☐ Yes	☐ No
Do you have a family history of ovarian cancer? If yes, whom?	☐ Yes	☐ No
Do you have a family history of osteoporosis? If yes, whom?	☐ Yes	☐ No
Do you have a family history of diabetes? If yes, whom?	☐ Yes	☐ No
Do you have a family history of hypertension? If yes, whom?	☐ Yes	☐ No
Do you have a family history of heart disease? If yes, whom?	☐ Yes	☐ No
Do you have a family history of kidney disease? If yes, whom?	☐ Yes	☐ No

Patient Signature: ____ Date: ________________________

FINANCIAL POLICY:

Byers Wellness Center does not file insurance for their patients. Payment for services must be made at time of service. We will be happy to provide you with a statement to file with your insurance company upon your request however we make no claim that our services will be reimbursed.

I understand that am responsible for my treatment at Byers Wellness Center and payment must be made at time of service.

Patient Signature: ____ Date: _____________

PATIENT CONSENT TO LEAVE DETAILED MESSAGE INFORMATION

Dr. Byers requires our staff to obtain prior authorization to leave voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine/voice mail or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr. Byers and/or his staff to leave a message regarding treatment, test results or other necessary information.

1) On answering machine at home- Phone Number:_______________________________________
2) On voice mail at work- Phone Number: _______________________________________
3) On cell phone voice mail- Phone Number: _______________________________________

Patient's Signature: ____ Date: _____________________

I DO NOT consent to any messages being left on an answering machine other than caller's name and phone number.

Patient's Signature: ____ Date: _____________________

EMAIL AND TEXT MESSAGING REMINDERS:

Byers Wellness Center will send appointment reminders and other important communications at various times using your email and/or text messaging to your cell phone. Please provide us an email address and cell phone number you would like for us to use.

Email: ____ Cell Phone: _________________________

I authorize Byers Wellness Center to contact me via the above email address and cell phone number in regards to appointment information and other pertinent information regarding their services.

Patient Signature: ____ Date: ______________________________

Disclaimer: We will never share your contact information with any other third party. Confidential patient information will never be sent through email or text messaging.

Byers Wellness Center – Sotto Pelle Treatment Pricing

MALE TREATMENT

Lab Work:

- Pre-Lab Work - All patients are required to have lab work completed prior to their first insertion. The fee for this lab work is $225.00
- Post-Lab Work – This test is generally taken 3 weeks after treatment until the baseline levels are set – then follow up labs are required every 6 months to monitor PSA levels. The fee for this lab work is $210.00

COST OF TREATMENT:

The cost of the initial treatment includes your consultation with Dr. Byers and the fee for the insertion.

1st Treatment – Consultation ($259.00) + Insertion ($800.00) = $1059.00

Follow Up Insertions: Typically follow up insertions are done every 3 to 4 months depending upon each patient. The cost for a follow up insertion is $800.00