Men's Health Boston Questionnaire

Date_____ Name _____

Date of Birth_____ Name of partner_____
Address:_____
Home Phone # _____ Work Phone# _____
Can a confidential message be left on an answering machine? Y or N
Name of Regular Referring Doctor:_____
Name of Primary Care Doctor if different from referring:_____
Primary Care Physician's telephone number:_____
Occupation _____
Briefly describe your symptoms or problems:_____
_____

List Medications (including herbals/vitamins)	List any and all surgeries and when? (vasectomy, varicocele surgery, hernia, etc)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Which medications/substances (including Latex) are you allergic to and reaction?
_____

Have you had any of the following (please circle). If yes, when?

Heart Disease/Heart Attack	Y/N	Chemical Exposure	Y/N
High Blood Pressure	Y/N	Radiation/Chemotherapy	Y/N
Diabetes	Y/N	Kidney Stones	Y/N
Bleeding Problems	Y/N	Blood in Urine	Y/N
Transfusions	Y/N	Low Testosterone	Y/N
Sexually Transmitted Diseases	Y/N	Undescended Testicles	Y/N
Urinary Tract Infections	Y/N	Prostate Cancer/Surgery	Y/N
Epididymitis	Y/N	Sleep Apnea	Y/N
Prostatitis	Y/N	Other problems?_____	

Any family history of prostate cancer? Y/N If yes, whom?_____
How many children to you have? ____ Ages/Gender?_____
Any Family History of infertility?_____
How much do you smoke? _____ How much alcohol do you drink?_____
Do you use any recreational drugs? Y/N If yes, which?_____
How often do you awake at night to urinate? ____ times
Is your urine stream weak? Y/N Do you feel you empty well? Y/N

Health Insurance Waiver for Non-Covered Services:

I understand that my health insurance may not cover certain services provided by any of the physicians at Men's Health Boston. Men's Health Boston is unable to verify each patient's health insurance coverage. Should you have questions regarding your coverage, it is your responsibility to verify your benefits with your insurance company prior to any scheduled appointment.

Authorization for Health Plan to Pay Directly to Physician:

I authorize payment from my insurance carrier directly to the health care providers at Men's Health Boston.

Managed Care Plan Participants:

I understand that I have an obligation to obtain a referral for specialty services from my Primary Care Physician prior to any scheduled appointment. I hereby agree to be responsible for full payment for services received if my specialist does not receive a referral and my insurance plan denies payment.

Name: _____

Date: _____

Men's Health Boston Consent to Discuss Medical Care

I _____, DOB_____,
Give permission to my physician and staff members of Men's Health Boston to discuss my medical condition and treatment with the following people.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____