New Patient Intake Form - Male

Please complete this form and return to info@cunninghamclinic.com, or by fax at 720-378-4698.

PATIENT INFORMATION:

Patient Name: | Today's Date:

Email: | Cell #:

Date of Birth: | Weight: | Height:

Address:

HEALTH INFORMATION:

Current Medications:

Supplements/Vitamins:

Surgeries:

Allergies:

SYMPTOM REVIEW:

Please check the box that best describes your symptoms (leave blank if not applicable):

Symptom	Mild	Moderate	Severe
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐
Decline in drive or interest (loss of "zest for life" feeling down or sad)		☐	☐
Sexual Desire or Performance (reduced or diminished)	☐	☐	☐
Erectile Changes (weaker erection, loss of morning erections)	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐
Ejaculations (infrequent or absent)	☐	☐	☐

Hair Loss, Thinning or change in texture of hair	☐	☐	☐
Feeling cold all the time / cold hands or feet	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐
Bladder Problems (difficulty urinating, increased need to urinate, incontinence)	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

ADDITIONAL MEDICAL HISTORY AND SCREENINGS

- Date of last date of Colonoscopy?: ___________ ☐ Normal ☐ Abnormal
- Date of last Physical: ___________ ☐ Normal ☐ Abnormal
- Currently Trying to Conceive: ☐ Yes ☐ No
- Desire to conceive in the future?: ☐ Yes ☐ No
- Are you on a 5-alpha reductase inhibitor? ☐ Yes ☐ No
- Are you on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)? ☐ Yes ☐ No
- Are you on any other testosterone boosting medication (Clomid, HCG, etc.)? ☐ Yes ☐ No
- Are you currently utilizing BHRT or HRT? ☐ Yes ☐ No
  - If yes, what type (check all that apply): ☐ Testosterone ☐ Progesterone ☐ Estrogen ☐ Thyroid
  - List dose of hormones: ____
- Are you taking a statin? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No
- Are you currently on oral nitrates? ☐ Yes ☐ No
- Are you currently seeing a Urologist? ☐ Yes ☐ No
  - If yes, indicate why and if you have been cleared to start Hormone Replacement Therapy:
  -
  - ____
- How many grams of protein do you consume daily?____________

Cardiovascular Conditions ☐ Heart Attack or Stroke (within last 6 months) ☐ DVT or Blood Clot (within last 6 months) ☐ Hypertension ☐ Hyperlipidemia ☐ Obstructive Sleep Apnea ☐ Atrial Fibrillation ☐Tachycardia ☐Patient Takes Anticoagulant Medication

☐ Desire to Maintain Fertility

Cancer ☐ Breast Cancer ☐ History/Active Prostate Cancer ☐ History/Active Thyroid Cancer ☐ Meningioma ☐ Polythemia Vera (PV) ☐ Other Cancers (Except Basal Cell Carcinoma):____________________________

Neurological Conditions ☐ Epilepsy or Seizure Disorder ☐ Depression/Anxiety

Endocrine and Metabolic ☐ PCOS ☐ 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 ☐ Psoriasis ☐ IBS (Irritable Bowel Syndrome) ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Positive ANA

Organ-Specific Conditions ☐ Liver Disease or History of Liver Disease ☐ Kidney Disease or History of Kidney Disease ☐ LAM (Lymphangioleiomyomatosis) ☐ Osteoporosis or Osteopenia ☐ HIV ☐ Hepatitis ☐ Hemochromatosis ☐ Pancreatitis or History of Pancreatitis ☐ History of Gallbladder Disease

SYMPTOMS AND CONCERNS (CHECK ALL THAT APPLY) ☐ ACNE ☐ INABILITY/DELAYED ORGASM ☐ URINARY INCONTINENCE ☐ FREQUENT URINARY TRACT INFECTIONS ☐ WEIGHT GAIN ☐ THINNING EYEBROWS ☐ COLD HANDS OR FEET ☐ BRITTLE NAILS ☐ DRY/FLAKING SKIN ☐ LACK OF ENERGY (FATIGUE) ☐ DECREASE IN MUSCLE MASS ☐ MIND RACING AT BEDTIME ☐ ERECTILE DYSFUNCTION (ED) ☐ DECREASED LIBIDO ☐ DECREASED DESIRE ☐ DIFFICULTY SLEEPING ☐ DECREASE IN STRENGTH/ENDURANCE ☐ DECREASE IN WORK PERFORMANCE ☐ MOOD SWINGS ☐ GYNECOMASTIA ☐ ABDOMINAL OBESITY ☐ MIND RACING AT BEDTIME

YOUR PRIMARY HEALTH CONCERNS AND GOALS:

Cunningham Clinic LLC Booking, Cancellation, Privacy, and Communication Policies

Booking: Cunningham Clinic offers both online and in-person booking options, including booking via phone or at the front desk. To secure an appointment, a credit card must be kept on file, stored securely within your electronic health record.

Cancellation: Cunningham Clinic employs a multi-tiered reminder system, which includes online booking, electronic appointment confirmations via email and text, and personal calls prior to the appointment date. If you miss your scheduled appointment or fail to cancel or reschedule at least 24 hours in advance (a "no call, no show"), a cancellation fee of $100 will be charged.

The only exception to this policy occurs in the rare event that another same-day appointment becomes available. If you are scheduled for a specific time (e.g., 11 a.m.) and can reschedule to an earlier or later time on the same day, no cancellation fee will apply.

Acknowledgment of Booking and Cancellation Policy: By booking an appointment with Cunningham Clinic, you acknowledge and agree to the terms and conditions outlined in the Booking and Cancellation Policy, as well as the Notice of Information Practices and Privacy Statement.

Notice of Information Practices and Privacy Statement:

- How We Collect Information About You: Cunningham Clinic collects information through various means such as letters, phone calls, emails, voicemails, and applications. This data is collected either as required by law or to provide healthcare services.

- What We Do Not Do With Your Information: Cunningham Clinic does not share, sell, rent, or distribute any patient information that is confidential, restricted by law, or protected under HIPAA, unless express consent is given.

- How We Use Your Information: Information is used solely to provide healthcare services, which may include communication with healthcare providers, pharmacies, insurance companies, and other necessary entities to ensure the accuracy of your medical records and determine the healthcare services or supplies you need.

- Limited Right to Use Non-Identifying Personal Information: Any pictures, letters, thank-you notes, or other correspondence sent to Cunningham Clinic become the property of the clinic. Non-identifying information may be used for promotional or fundraising purposes directly related to our mission. No personally identifiable information will be used without explicit consent.

- Privacy Protection: We respect your right to privacy. No personal information or photos sent to Cunningham Clinic will be publicly used without your consent.

SMS and Email Communication: Cunningham Clinic strongly recommends using the patient portal in the Electronic Health Record (EHR) for all communication, as it ensures the protection of your medical information. If you choose to communicate via SMS (text message) or personal email, you waive HIPAA protection for those communications. This agreement will remain in effect until you submit a written request to cancel it.

HIPAA Acknowledgement: I acknowledge and understand the HIPAA policies of Cunningham Clinic.

Signature ______________________________

Date ____________