VITALITY HEALTH

302-643-2500

MALE BIOTE PATIENT INFORMATION		
Name		Date of Birth
Address:		City:
State / Zip		
Cell Phone		Addl Phone
Email Address (Required to access patient portal)		
Gender		Married Single Widowed Divorced
Ethnicity	Not Hispanic or Latino	Hispanic or Latino
Race	White Black or African American	Native American Asian Other
PREFERRED PHARMACY		
Pharmacy Name		Phone:
Pharmacy Address		
INSURANCE INFORMATION		
Insurance Co Name		
Policy No		GROUP:
SECONDARY INSURANCE		
Insurance Co Name		
Policy		Group No
Guarantor Name		Date of Birth
EMERGENCY CONTACT		
Name & Cell Phone		
PRIMARY PHYSICIAN INFORMATION		

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Name	
Address/Phone	

MEDICATIONS

Please List All Medications & Dosages. Include Birth Control Pills, Over-The Counter Medicines, Herbals, And Vitamins.

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBED BY AND REASON

ADULT PERSONAL HEALTH HISTORY

HAVE YOU BEEN DIAGNOSED WITH THE FOLLOWING:

	Diabetes		Arthritis		Anxiety
	Hypothyroidism		Osteoporosis		Bipolar
	High Blood Pressure		COPD		Cancer
	High Cholesterol		Asthma		Kidney disease
	Stroke		Lupus		Liver disease (Hepatitis)
	Heart attack		Migraines		
	Heart Arrhythmia (Afib)		Seizures		
	Blood clots (Leg, Arm, Lung)		Depression		

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATION? _____

MEDICATIONS	REACTION

DO YOU HAVE ANY ALLERGIES ? _____

SURGICAL HISTORY (Check all that apply) ☐ I HAVE NEVER HAD SURGERY

DATE	REASON FOR SURGERY

FAMILY HISTORY

☐ NO SIGNIFICANT FAMILY HISTORY ☐ I WAS ADOPTED

Check And List Family Members (Mother, Father, Brother, Sister and Children) Had The Following:

Family Member	Alive /Deceased	Age/Age at death	Illness
Father			Diabetes Heart Disease High Cholesterol Cancer : Type_____Hypertension Stroke
Mother			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Siblings			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Children			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke

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SOCIAL HISTORY

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W PARTNER	ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ MEN ☐ WOMEN ☐ BOTH ☐ PREVIOUSLY NOT NOW
DRINK ALCHOHOL ☐ YES ☐ NO ☐ FORMER HOW MANY DRINKS/WEEK	DO YOU EXERCISE ☐ YES ☐ NO
DO YOU SMOKE ☐ NO ☐ CURRENT SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS	☐ FORMER SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS
HAVE YOU USED ANY IN THE LAST YEAR? ☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ OTHER	DO YOU USE ANY OTHER SUBSTANCES? ☐ YES ☐ NO IF YES, WHAT TYPE _____

HEALTH SCREENINGS

Have you ever had a colonoscopy? ☐ Yes ☐ No

Month/Year of last colonoscopy? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain:_____

Have you ever had a Cholesterol test? ☐ Yes ☐ No

Have you ever been tested for diabetes? ☐ YES ☐ NO

Month/year of last Diabetes test? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain _____

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Hormone Male Health Questionnaire

Patient Name _____ DOB _____

SYMPTOMS	NONE	MILD	MODERATE	SEVERE
Physical Exhaustions (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)				
Decline in drive or interest (loss of 'zest for life', feeling down or sad				
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)				
Difficulties with memory (concentration, finding the right word, or retaining information)				
Sexual Desire or Performance (reduced or diminished)				
Erectile changes (weaker erections, loss of morning erections)				
Sweating (night sweats or increased episodes of sweating)				
Hair loss, thinning or change in texture of hair				
Feeling cold all the time, having cold hands or feet				
Headaches or migraines (increase in frequency or intensity)				
Weight (difficulty losing weight despite diet/exercise)				
Bladder problems (difficulty in urinating, increased need to urinate, incontinence				