Patient Intake Information

First Name:______________________ Middle Initial:______ Last Name:_____________________

DOB:________________ Gender:_______________ Gender prefix preference:_________________

Phone:________________ Okay with text messaging:____ Email address:____________________

Preferred Mode of Communication:____

Home/mailing Address:____

Emergency Contact Name/Phone:____

Past Medical History:____

Past Surgical History:____

Do you smoke:____Yes ____No If yes, amount per day:___________ Number of years:_______

Do you drink alcohol:____Yes ____No If yes, amount per week:_________ Number of years:___

Do you use illicit drugs:_____, If yes, what type and amount:_______________________________

Family History:____

Allergies:____

List of medications:____

Do you have a primary care physician:______ If yes, name and address:_____________________

How did you hear about us:____

Service(s) sought, check all that apply.

________Weight loss initial appointment

________Weight loss follow up appointment

________Testosterone replacement therapy initial appointment

________Testosterone replacement therapy follow up appointment

________Injectables, please specify which one____

________IV therapy, please specify which one____