Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars ____ per day. ☐ I use e-cigarettes ____ a day. ☐ I use caffeine ____ a day.

☐ I drink alcoholic beverages ____ per week. ☐ I drink more than 10 alcoholic beverages a week.

Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Cancer (type):
  Year: _____
- ☐ Elevated PSA
- ☐ Trouble passing urine
- ☐ Taking medicine for prostate or male-pattern balding
- ☐ History of anemia
- ☐ Vasectomy
- ☐ Erectile dysfunction
- ☐ Testicular or prostate cancer
- ☐ Prostate enlargement or BPH
- ☐ Kidney disease or decreased kidney function
- ☐ Frequent blood donations
- ☐ Non-cancerous testicular or prostate surgery
- ☐ Severe snoring
- ☐ Taking medicine for high cholesterol

Birth Control Method:

- ☐ Not applicable
- ☐ None - planning pregnancy in the next year
- ☐ Depend on partner's contraception
- ☐ Vasectomy
- ☐ Condoms
- ☐ Other: _____

Activity Level:

- ☐ Low – sedentary
- ☐ Moderate – walk/jog/workout infrequently
- ☐ Average – walk/jog/workout 1 to 3 times per week
- ☐ High – walk/jog/workout regularly 4+ times per week

Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

MALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY 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)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐
Ejaculations (infrequent or absent)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss, rapid or thinning	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

Medical History & Questionnaire

Name:_____ Age:_____ Date of Birth:__/__/__ Gender: M F

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home:_____ Work:_____ Cell:_____

E-Mail:_____ How Did You Hear About Us:_____

In Case of Emergency, Who May We Contact?_____ Phone:_____

Pharmacy: _____

Medical History

Have you ever had (please check all that apply):

__ Heart Disease/Heart Attack __ Diabetes __ History of Cancer

__ Chronic Skin Conditions __ Lupus __ HIV or AIDS

__ Hypertension __ Epilepsy __ Endocrine/Hormone Disorder

__ Heart Pacemaker or Defibrillator __ Hepatitis __ Planning/Current or Recent Pregnancy

List any active medical problems you have: _____

List any medications you currently take: _____

List any medication allergies you have: _____

Are you allergic to any numbing agents? _____ Are you allergic to latex? _____ Smoke? _____

Surgical History

List any operations you have had with the year:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Dermatologic History

Have you ever had (please check all that apply):

__ Varicose or Spider Veins __ Self Tanner __ Laser Skin Resurfacing

__ Photosensitivity __ Herpes Simplex or Cold Sores __ Chemical Peel

__ Keloid or Hypertrophic Scar __ Accutane use for Acne __ Botox®,Dysport®, or Xeomin®Inj.

__ Pigmentation Disorder __ Antibiotics use Regularly __ Inj. Of Collagen or other Dermal fillers

__ Recent Waxing or Plucking __ Electrolysis or Threading __ Recent Sunburn or Tan (Including Tanning Bed)

What is your ethnic background? _____

When Exposed to the sun, do you usually: __ Always Burn, Never Tan __ Burn Easily, Tan Poorly __ Tan after Initial Burn __ Burn Minimally, Tan easily __ Rarely Burn, Tan Dark Easily __ Never Burn, Always Tan Dark

List any special skin care products you use including retin-a, retinol, anti-aging products:

_____

Client Signature: _____ Date: _____

Parent or Guardian (if patient is under 18 years of age): _____

General Consent

Thank you for choosing Vita Sana Clinic. On our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. This form shall serve as a permanent consent form along with each and every procedure consent form signed by you for services rendered by Vita Sana Clinic.

Anesthesia

I understand that use of a topical anesthetic is optional and will only be applied upon my request. I understand that the topical anesthetic is designed to decrease my sensation of discomfort associated with the carious treatments.

I also understand that individual variance and equipment settings will affect any perceived level of discomfort.

I will fully disclose my personal medical history, including any medications I may be taking, in order to assist with the choice, if any, of topical anesthesia.

If using an over-the-counter (non-prescription) topical anesthetic product I assume all risks associated with its use and will discuss such use with my pharmacist or personal physician prior to application. This includes any product obtained through or at the recommendation of Vita Sana Clinic.

If using a prescription product, I will review its use with the prescribing physician and with the dispensing pharmacist. I will not use such a product until ai am fully informed of its need, potential complications and cautions associated with its use.

I understand that, in general, topical anesthetics are not to be used by anyone allergic to “Caine” type medications, anyone who is pregnant or nursing, or anyone with a history of seizure or liver disease. Topical anesthetic is not to be used on damaged or non-intact skin, open sores, or inside the mouth. I will obtain and review any product-specific cautions and information prior to using the medication.

Disclosure

I will disclose a full and accurate personal medical history to include any and all information regarding medical conditions and my use if medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

Confidentiality

I understand that no information regarding services performed shall be released without my express consent except as herein stated. I understand that, in addition to authorized Vita Sana personnel, the clinic’s Medical Director and Consulting Physicians shall have full access to my treatment records. I also understand that appropriate medical assessment may be conducted to further the safety and efficacy of Vita Sana Clinic services. I understand that there may be a charge for my medical assessment. I understand that Vita Sana Clinic will maintain file copies of all records.

Continued Consent

I understand that Vita Sana Clinic services consist of ongoing treatments to achieve maximum benefit, and this consent shall apply to all services rendered to me by Vita Sama Clinic, including ongoing or intermittent treatments.

Photographs

I understand that photographs may be taken to document treatment results, however, they will not be released or used otherwise without my specific verbal or written consent.

Guarantee

I understand that no specific guarantees are implied or made by this consent form.

I certify that I am a competent adult of at least 18 years of age.

My signature attests to the fact that I have fully read this entire consent form and that any questions or concerns have been answered to my satisfaction, and that I understand and agree to the information contained within.

Date: _____

Signed: _____

Printed Name: _____

Parent or Legal Guardian: _____ (for minors under age 18)

VitaSana
PLASTIC SURGERY
& WELLNESS CLINIC

No Show Fee

In order to assure that all of our patients receive the best care possible, our clinic asks that all rescheduled appointments and cancellations are made within 48 hours of the scheduled appointment time.

I, _____ , understand that there will be a $75 fee for rescheduled appointments and cancellations made within less than 48 hours of any scheduled appointment time. Appointments rescheduled or cancelled with less than 24 hours the patient will be charged 50% of the procedure fee.

- I agree to reschedule appointments and make any cancellations, that may be necessary, 48 hours prior to scheduled appointment times.

- I understand if failure to do so, I will be charged a $75 fee or 50% of procedure depending upon time prior to scheduled appointment.

_____ _____

Patient Signature Date

Vita Sana Clinic

Patient Photographic Consent and Release

I, _____ consent to the taking of photographs and/or video by Dr. Burgess or her designee, of me or parts of my body for medical documentation purposes.

I understand that such photographs may be published in any print, visual, or internet media, specifically including but not limited to medical journals and textbooks, for the purpose of informing the medical profession or the general public about surgical methods. This includes but is not limited to print, non-print, all languages, world rights, subsequent editions, and derivatives, such as promotional material or online platforms.

Neither I, nor any member of my family will be identified by name in any publication. I understand that in many circumstances the photographs may portray features which shall make my identity recognizable. I may revoke consent at any point in the future should I choose. Photos available in public forums (social media) can be copied by other people/ entities despite watermarking, and this may be objectionable.

I release and discharge Dr. Burgess and associates and all parties acting under their license and authority from all rights that I may have in such photographs and from any claim that I may have relating to their use in such publication, including any claim for payment in connection with distribution or publication of photographs. I understand that I will receive no compensation for these photographs.

Patient consultations
Presentations/Publications
Social Media (e.g. to include Instagram__, blogs__, websites__, Facebook__)

I grant this consent voluntarily and certify that I have read and understood the above Consent and Release.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Signature of Physician or Witness **Date**