The Youth Fountain, LLC

Emil Shakov MD, FACS
501 Iron Bridge Road, Suite 9
Freehold, NJ 07728
(866) 514-0025

Male Anti-Aging Form

Name: _____ Date: _____ Email: _____

Birthdate: _____ Social Security Number: _____

Primary Care Physician: _____ Urologist: _____

How did you hear about us? _____

Current Medications/Supplements and Doses: _____

_____

Present Symptoms: _____

Allergies/Reaction: _____

Check any of these symptoms that apply:

Androgen Deficiency		
Low libido	Decreased erections	Problem with memory/concentration
Lack of energy	Decreased ability to play sports	Sad or grumpy
Decreased strength/energy	Fall asleep after dinner	Recent deterioration of work performance
Lost height	Sleep disturbances	Decreased enjoyment of life
Decreased muscle mass		

Check any of these symptoms that apply:

Cortisol Excess		Cortisol Deficiency
Sleep disturbance	Irritable, Anxious	Fatigue
Heart palpitations	New or worsened blood pressure	Salt craving
Bone loss	Memory lapses	Chemical sensitivity
Fatigue	Headaches	Allergies
Weight gain – waist	Stress	Stress
Loss of muscle mass	Nervousness	Apathy/decreased passion for life
Thinning skin	Glucose intolerance	Irritable
Elevated triglycerides	Low libido	Arthritis
Hair loss	Cognitive difficulties	Cold body temperature
Acne	Erectile dysfunction	Aches/Pains

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Check any of these symptoms that apply:

Thyroid Excess		Thyroid Deficiency	
Heat Intolerance	Muscle Weakness	Cold Intolerance	Inability to lose weight
Voice has become hoarse	Panic attacks	Constipation	Stress
Heart palpitations	Coarse dry skin	Fatigue	Cold body temperature
Tremors / Shakiness	Insomnia	Weakness	Irritable
Weight loss	Infertility	Unexplained weight gain	Lack of motivation
Diarrhea	Nervous / Anxious	Aches / Pains	Muscle cramps

Check any of these symptoms that apply:

Growth Hormone Deficiency		
A higher level of body fat	Decreased sexual function and interest	Feelings of isolation
Anxiety and depression	Fatigue	Greater sensitivity to heat and cold
Less muscle	Less strength and stamina	Reduced bone density
Elevated LDL	Elevated triglycerides	Decreased ability to exercise

Date of last prostate exam: _____ Have you had an abnormal prostate exam? _____

Have you ever had elevated PSA?: _____ Have you had prostate biopsy? _____

If yes, what were the results? _____

Circle any of the following if you have a history of the following cancer:

Lung	Breast	Colon	Leukemia	Prostate	Skin	Lymphoma	Other:

Have you been treated with hormones in the past? If yes, please explain. _____

_____

Past Medical History: _____

_____

Past Surgical History: _____

_____

Family History: _____

Smoke, if yes how much? _____ Drink alcohol, if yes how much? _____

Recreational drugs, If yes which and how much? _____

Exercise, which and how often? _____

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Review of symptoms: please check all that apply

General	Recent change in usual weight	Weakness	Fatigue	Fever			
Skin	Rash	Lumps	Sores	Itching	Dryness	Color Change	Change in hair or nails
Head	Headaches	Head injury					
Eyes	Vision problems	Glasses	Pain	Redness	Excessive tearing		
Ears	Change in hearing	Ringing sound	Room spins/ dizzy	Earache	Hearing aids		
Nose/Sinuses	Frequent colds	Nasal stuffiness	Discharge	Nose bleeds	Sinus trouble		
Mouth/Throat	Bleeding gums	Dentures	Sore throat	Dry mouth	Sores	Hoarseness	
Neck	Lumps	Swollen glands	Pain	Stiffness	Goiter		
Breasts	Lumps	Pain	Discomfort	Nipple Discharge	Change in Self-examination	Do not perform self-examination	
Respiratory	Cough	Sputum	Blood in sputum	Wheezing	Asthma	Bronchitis	Emphysema
	Pneumonia	Tuberculosis	Pleurisy				
Cardiac	Heart trouble	High blood pressure	Rheumatic fever	Heart murmur	Chest pain	Shortness of breath	
Gastrointestinal	Trouble swallowing	Heartburn	Change in appetite	Nausea	Vomiting	Regurgitation	Change in bowel movements
	Rectal bleeding	Constipation	Hemorrhoids	Diarrhea	Abdominal pain	Food intolerance	Gas
Urinary	Change in frequency of urination	Excessive urination	Blood in urine	Incontinence	Urinary infection	Stones	
Genital	Hernia	Sores	Discharge	Rash	Pain	Bleeding	Itching
	Sexual dysfunction						
Vascular	Leg pain	Leg cramps	Varicose veins	Blood clots in the past			
Musculoskeletal	Muscle pain or join pain	Stiffness	Arthritis	Gout	Backache		
Neurological	Fainting/ Blackouts	Seizures	Weakness	Paralysis	Numbness or loss of sensation	Tingling	“Pins and needles”
	Tremors						
Hematological	Anemia	Easy bruising	Bleeding	Bad reaction to previous transfusions			
Endocrine	Heat or cold intolerance	Excessive sweating	Diabetes	Excessive thirst or hunger	Excessive urination		
Psychiatric	Nervousness	Tension	Depression	Other psychiatric problems	Memory Problems		

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While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life-threatening symptoms that you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements, is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from The Youth Fountain, LLC, its staff, or treating providers for injury to you on account of involvement in the bio-identical hormone replacement program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

Print Signature: _____ Date: _____

Patient Name: _____

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement is adherence to routine cancer/prostate screening. You must have routine physical examinations including a prostate examination and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the bio-identical hormone replacement therapy program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

Print Signature: _____ Date: _____

Patient Name: _____

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

The Youth Fountain, LLC will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THE AFOREMENTIONED AUTHORIZATION.

By signing this authorization, you acknowledge and agree that The Youth Fountain, LLC may not use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health without patient permission.

By signing this authorization, you agree that The Youth Fountain, LLC or its Business Associates may not disclose your personal health care information to a requesting entity or health care provider without your express permission.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand The Youth Fountain, LLC Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While The Youth Fountain, LLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from The Youth Fountain, LLC at any of its offices.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by The Youth Fountain, LLC for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that The Youth Fountain, LLC has taken action in reliance on it. A revocation is effective upon receipt by The Youth Fountain, LLC of a written request to revoke and a copy of the executed authorization form be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of The Youth Fountain, LLC or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

The Youth Fountain, LLC will provide the undersigned with a copy of this signed authorization at his or her request.

Acknowledge and agreed to by:

Patient Name: _____ Date: _____

Patient Signature: _____

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Patient Registration Form

Patient Information

Name: _____ Date: _____

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

Age: _____ Birthdate: _____ Female / Male

SSN (Last 4 Digits): _____ Email Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

How would you prefer to receive automatic appointment reminders? ☐ Text ☐ Call ☐ E-Mail

Employer: _____ Occupation: _____

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

Emergency Contact: _____ Phone Number: _____