NEW PATIENT (Male)
BioTE HEALTH ASSESSMENT FORM

404-919-6649
1655 Lebanon Road, Suite C
Lawrenceville, GA 30043
contact@sugarloafwellnesscenter.com

INSTRUCTIONS:
Complete this form BEFORE your initial consultation with your doctor. You may print then fill out the form or complete the fillable form fields then print your form.

SUBMISSION:
Either bring these completed forms with you to your appointment, or send them to us via Perisseia Primary Care's Patient Portal.

PATIENT PORTAL:
Visit perisseiaprimarycare.com or sugarloafwellnesscenter.com and click "PATIENT LOGIN" in the top right of the webpage. Login and use your patient portal to send a message to Dr. Kunz after attaching your forms to that message.

Sugarloaf Wellness Center

Address and Contact Information

Name: _____ Date of Birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

Sugarloaf Wellness Center

Address and Contact Information

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 smoke cigarettes or cigars___ per day. ☐ I use caffeine___ per day. ☐ I use e-cigarettes___per day.

☐ I have completed my family. ☐ My partner and I would like to have more children in the near future.

☐ I have no biological children. If this is true, have you tried to have children? ☐ Yes ☐ No

If you have not had children, have you had prior semen analysis? ☐ Yes ☐ No

Sugarloaf Wellness Center

Address and Contact Information

Name: _____ Date of Birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Family History:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's or dementia ☐ Prostate cancer

Medication & Other Pertinent Information

Any known 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 Testosterone Replacement? ☐ Yes ☐ No If yes, are you on estrogen blocker? ☐ Yes ☐ No

Past Testosterone Replacement Therapy: _____

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

Other Medical Conditions:

☐ High blood pressure or hypertension
☐ Heart disease
☐ Atrial fibrillation or other arrhythmia
☐ Blood clot and/or a pulmonary emboli
☐ Depression/anxiety
☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
☐ Taking Proscar (finasteride), Flomax (Tamsulosin) or Avodart (dutasteride)
☐ 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 _____

Name: _____ Date of Birth: _____

POST-INSERTION INSTRUCTIONS FOR MEN

- Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip, and the outer layer is a waterproof dressing.
- We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.
- **No tub baths, hot tubs, or swimming pools for 7 days.** You may shower, but do not remove the bandage or steri-strips for 7 days.
- No major exercises for the incision area. No heavy lifting using the legs for 7 days. This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surface.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (50 mg orally every 6 hours). Caution: this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks. If the redness worsens after the first 2-3 days, please contact the office.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes. Please call if you have any bleeding (not oozing) not relieved with pressure, as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

REMINDERS:

Remember to schedule your post-insertion blood work drawn 4 weeks after your FIRST insertion

ADDITIONAL INSTRUCTIONS:

_____

_____

_____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Print Name: _____

Signature: _____

Date: _____