Dr. Nael Dagstani / 215 S Power Power Rd / Power Medical Ctr/ North Building #105 / Mesa AZ 85260
480 861 3916 p 480 664 1989 f

MALE PATIENT INFORMATION

Name:______________________________ Today's Date _______________

Date of Birth __________ Social Security # ____________________

Street address:____

City: ________________ State: ________ Zip ______________

Phone Numbers: Home _______________ Cell ______________

Do you have an email you can share with us? _____________________________

Patient employed by: ____

Business address: ____

Business phone: ________________________________

Marital status (please circle) Married Divorced Single Widow Living with Sig Other

Partner's Name: __________________________________

Spouse's phone: __________________________________

Your Signature: ____________________________________ Date ____________

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific:

____

____

____

____

____

1) Are you currently sexually active?	Yes	No
2) Do you have a history of Sexually Transmitted Diseases?	Yes	No
3) Have you had a sperm count:	Yes	No
4) Have you had the mumps?	Yes	No
5) Have you had Testicular Cancer?	Yes	No
6) Do you have Prostate problems?	Yes	No

If yes, please describe

____

____

____

7) Have you had any bladder or kidney problems?	Yes	No

8) Do you have erectile dysfunction:
If yes, please describe

____

9) Do you have heart problems?	Yes	No

10) Do you experience:

Fatigue	Yes	No
Decrease in memory	Yes	No
Decreased sexual drive	Yes	No
Decrease in exercise response	Yes	No
Poor recovery from exercise	Yes	No
Anxiety	Yes	No
Irritability	Yes	No
Mood swings	Yes	No
Migraines	Yes	No
Night sweats	Yes	No

How have you dealt with these symptoms?

____

____

____

____

____

11) Do you initiate intercourse	Yes	No
12) Is intercourse satisfying	Yes	No
13) Do you achieve orgasm	Yes	No
14) Do you suffer from premature ejaculation	Yes	No

15) How often do you have intercourse?

____

16) Is your sex drive the same as it was 5 years ago? Yes No
If no, please describe

____

____

17) List any other sexual dysfunctions

____

____

____

18) Have you experienced any weight gain in the past 1-2 years Yes No
if yes, please describe

____

____

19) Have you ever had your testosterone level taken Yes No
If yes, please describe (when, result if known, etc)

____

____

20) List current medications:

____

____

____

____

____

PAST MEDICAL HISTORY

1. Do you have diabetes	Yes	No
2. Do you have/had hypertension	Yes	No
3. Do you have heart disease	Yes	No
4. Do you have a heart murmur	Yes	No
5 Do you have/had kidney diease	Yes	No
6. Have you ever been treated for any psychiatric problems	Yes	No
7. Have you ever had rheumatic fever	Yes	No
8. Do you have mitral valve prolapse	Yes	No
9. Have you ever had hepatitis/liver disease	Yes	No
10. Have you ever had thyroid problems	Yes	No
11. Do you have arthritis	Yes	No
12. Do you have any drug allergies	Yes	No

____

____

13. Please list any surgeries and/or hospitalizations

____

____

____

____

____

____

____

14. Have you had any local anesthesia complications (at the dentist, etc)
Yes No

Please describe ____

15. Have you ever been anemic Yes No

16. Do you have a primary care or family doctor Yes No

Please list name, phone, address as much as possible

____

____

____

17. Have you had your cholesterol checked? Yes No

Was it normal

____

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SOCIAL HISTORY

1. Do you smoke cigarettes Yes No
if yes, per day ________________ # of years _________

2. Do you use street drugs Yes No

____

3. Do you drink alcohol Yes No
If yes, how much

____

THANK YOU!

Dr. Nael Dagstani
480 861 3916
drdagstani.com

Informed Consent
Medical Diagnosis and Treatment

I understand that Dr. Nael Dagstani NMD is licensed as a physician by the State of Arizona Naturopathic Physicians Board of Medical Examiners.

I understand that Dr. Dagstani subscribes to the accepted standard of care for practice of Naturopathic Medicine. The practice of Naturopathic Medicine means a medical systemof diagnosing and treating the human mind and body utilizing various modalities that includes Botanical/Pharmacologic intervention, Homeopathy, Clinical/Medical Nutrition, Parenteral (IV) nutrient therapy, Naturopathic Manipulative Therapy (NMT), Minor surgical procedures, and other forms of hygienic and physiotherapeutic techniques.

I understand that Dr. Dagstani may use one or several of the above listed modalities for my treatment in accordance with our agreed upon care plan.

I understand that I will not be involved in any research or experimental project without my full knowledge and consent.

I give my general consent for Dr. Dagstani to administer to my needs according to the standards of Naturopathic Medical training and practice in the State of Arizona.

I understand that my insurance generally will not pay for these services (although most will pay for any ordered radiologic or laboratory tests, and prescription medications depending on my plan), that if I am part of an HMO or any Medicare that Dr. Dagstani is not a participant in these plans and my services should not be submitted to these plans specifically.

____
Patient Name

______________________________ ______________
Signature Date

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480 861 3916 p 602 910 5504 f

HIPAA - Health Insurance Portability and Accountability Act

YOUR RIGHTS - Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION - You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES - With your written consent we may disclose to family members, close personal friends or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without our authorizatrion, in the following circumstances:

For public health activities (reporting of disease, injury, birth, death or suspicion of child abuse, neglect, or other domestic violence)

To government authority if we believe an individual is a victim of abuse, neglect or domestic violence

For health oversight activities (for example audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)

For judicial or administrative proceedings (i.e. pursuant to a court order, subpoena or discovery request)

For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)

To avert a serious threat to health or safety under certain circumstances

For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution

For compliance with workers compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose HIV/AIDS related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

____________________________ ________________

Patient signature Date

Dr. Nael Dagstani / 215 S Power Power Rd / North Building #105 / Mesa AZ 85206
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Male Testosterone Acknowledgement Form

Although Pellet Hormone Therapy has been approved for human use, there are relatively few doctors who currently administer testosterone pellets in the United States. I realize that this is not the usual and customary means of prescribing testosterone. I realize that the advantages of testosterone for men often include: a) behavioral changes including decreasing depression, decreasing anxiety and irritability, increasing energy and motivation, stabilizing mood, allowing one to cope better, improving one's self-image and self-worth, and enhancing one's stamina; b) improvement in one's cognitive function, i.e. reducing "brain fog", improving short-term memory and allowing one to stay focused to complete a task; c) physical effects such as decreasing total body fat, increasing lean body mass, increasing muscle mass, and increasing bone mass; and d) sexual benefits such as increasing libido, increasing early morning erections, increasing firmness and duration of erections.

I realize there are potential concerns with testosterone therapy and they include the possibility of enhancing a current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test and possibly a digital rectal exam should be done annually. If there is any question about possible prostate cancer, I consent to a follow-up with an ultrasound of the prostate gland.

I realize that there is an issue with male athletes abusing testosterone. When taking large quantities of *SYNTHETIC* testosterone, there may be resultant heart problems and elevated cholesterol. However, low dose, non-oral, natural testosterone that is used in bio-identical hormone therapy has not been associated with these problems.

Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood count may be done at least annually, and it is suggested that patients donate blood, a worthy endeavor, 1-3 times annually to prevent blood thickening from occurring.

Especially in younger men, testosterone administration can suppress the development of sperm and sperm count could dramatically reduce while a person is on testosterone therapy. However, to date, this appears to be, in the majority of men, a reversible process. Once the testosterone is discontinued, the sperm count is restored, usually in 6 - 12 months. This is an extremely important point to be aware of, in particular for younger men taking testosterone therapy. In this early stage, we have encouraged them to produce samples and have them frozen, just in case there is any permanent long-term effect on their situation. We have encouraged any men who are concerned about their fertility in the future to have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone administration is not to be used as a form of male contraception.

My signature certifies that I have read the above and acknowledge I have been encouraged to ask any questions regarding testosterone pellets. Individual results may of course vary.

Patient Signature ______________________________ Date ___________

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CONSENT FOR HORMONE IMPLANTATION

I, ___________________________ (patient) authorize Nael Dagstani, NMD, to perform sterile minor surgical placement of hormone pellets under the skin.

I understand the reason for the procedure is hormone therapy using estradiol and/or testosterone hormones.

I acknowledge that risks of this minor surgical procedure include possible infection and/or bleeding, among others.

LOCAL ANESTHESIA is used and involves risk, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be necessary.

I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

____________________________ ______________________

patient signature & dob date