

New Patient Questionnaire



MEN'S HEALTH BOSTON

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Can a confidential message be left on your voicemail? Y or N E-Mail: _____

Occupation: _____ Work Phone: _____

Partner's Name: _____ Partner's Age: _____

Name of Referring Doctor: _____

Name of Primary Care Physician (if different from referring): _____

Briefly describe your symptoms or problems: _____

List Medications:
(include herbals/vitamins)

List any and all surgeries, and when:
(vasectomy, varicocele surgery, hernia, etc.)

Which medications/substances (including Latex) are you allergic to and what type of reaction did you have:

Have you had any of the following (please circle). If yes, when?

Heart Disease/Heart Attack	Y N	Chemical Exposure	Y N
High Blood Pressure	Y N	Radiation/Chemotherapy	Y N
Diabetes	Y N	Kidney Stones	Y N
Bleeding Problems	Y N	Blood in Urine	Y N
Transfusions	Y N	Low Testosterone	Y N
Sexually Transmitted Diseases	Y N	Undescended Testicles	Y N
Urinary Tract Infections	Y N	Prostate Cancer/Surgery	Y N
Epididymitis	Y N	Sleep Apnea	Y N
Prostatitis	Y N	Other Problems?	_____

Do you have a family history of prostate cancer? Y N If yes, whom? _____

How many children do you have?: _____ Ages/Genders: _____

Do you smoke cigarettes? Y N How Often: _____ How much alcohol do you drink?: _____

How often do you wake up at night to urinate? _____ times. Is your urine stream weak? Y N

Physician Notes:

Health Insurance Waiver for Non-Covered Services:

I understand that my health insurance may not cover certain services provided by any of the physicians at Men's Health Boston. Men's Health Boston is unable to verify each patient's health insurance coverage. Should you have questions regarding your coverage, it is your responsibility to verify your benefits with your insurance company prior to any scheduled appointment.

Authorization for Health Plan to Pay Directly to Physician:

I authorize payment from my insurance carrier directly to the health care providers at Men's Health Boston.

Managed Care Plan Participants:

I understand that I have an obligation to obtain a referral for specialty services from my Primary Care Physician prior to any scheduled appointment. I hereby agree to be responsible for full payment for services received if my specialist does not receive a referral and my insurance plan denies payment.

Cancellation Fee:

I understand that it is my responsibility to cancel or reschedule my appointment more than 24 hours before a scheduled appointment or test. I understand that failure to do so will result in a \$40.00 fee.

Name: _____

Date: _____