NEW RIVER WOMEN'S Health

3708 S. Main St., Suite D
Blacksburg, VA 24060
(540) 605-7566
www.newriverwomenshealth.com/

1. Please enter your information.

First Name: ____ Middle Initials: ____ Last Name: ____ Date of Birth: ____

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: ____

Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Mobile Phone: ____ Home Phone: ____ Work Phone: ____

Email: ____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Clinical Profile-Male

2. Employment/Profession:

3. Spouse/Partner's Name:

4. Primary Care Physician:

5. Medication Allergies:

6. List Current Medications (including over the counter):

7. Tobacco use:

○ Yes
○ No

If Yes, how long, how much? ____________________________

8. Alcohol Use:

○ Yes
○ No

If yes, how many drinks per week: _______________________

9. Recreational Drug Use:

○ Yes
○ No

If yes, what and how often? ______________________________

10. Date of last Annual Physical:

11. Date of Last colonoscopy:

12. Date of Last Prostate Check:

13. Date of last Cholesterol Check:

14. Have you been tested for HIV?

- YES
- NO

If yes, what was the result? ___________________________

15. Sexual Orientation:

- Heterosexual
- Homosexual
- Bisexual
- Other

If other, please explain ____________________________

16. Have you fathered any children?

- Yes
- No

If yes, how many? ___________________

17. What age was your first intercourse experience?

18. Are you currently sexually active?

- Yes
- No

If yes, how often? _________________________

19. Do you initiate intercourse?

- Yes
- No

20. Do you achieve orgasm?

- Yes
- No

21. Do you find intercourse satisfying?

- Yes
- No

22. Have you had any sexually transmitted diseases (STDs)?

- Yes
- No

If Yes, please list: ____

23. Do you suffer from premature ejaculation?

- Yes
- No

24. Have you had a sperm count done?

- Yes
- No

If yes, what were the results? _________________

25. Have you had the mumps?

- Yes
- No

26. Do you have prostate problems?

- Yes
- No

If yes, please explain? ____

27. Have you had blood in your urine?

- Yes
- No

If yes, please explain? ____

28. Do you have bladder or kidney issues?

- ○ Yes
- ○ No

If yes, please explain: ____________________________________

____

29. Do you have erectile dysfunction?

- ○ Yes
- ○ No

If yes, please explain: _____________________________________

____

30. Have you had your testosterone checked?

- ○ Yes
- ○ No

If yes, what was the result? ____________________________

____

31. Is your sex drive similar to what it was 5 years ago?

- ○ Yes
- ○ No

32. List any other sexual dysfunctions:

____

33. Do you suffer from any of the following? (Circle any that apply)

☐ Fatigue	☐ Memory loss	☐ Decreased energy level
☐ Decreased sexual desire	☐ Anxiety	☐ Irritability
☐ Migraines	☐ Mental foggyness	☐ Muscle loss
☐ Weight gain or weight loss		

What have you tried to help these issues:
____

____

Past Medical History (circle all that apply)

34. Do you currently have or have you had any of the below:

- ☐ Heart Attack
- ☐ Hypertension
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Thyroid Disorder
- ☐ Asthma/Emphysema
- ☐ Osteopenia/Osteoporosis
- ☐ Depression
- ☐ Chronic Kidney Disease
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Lupus
- ☐ Colon Polyp
- ☐ Gastrointestinal Disorder
- ☐ Diabetes
- ☐ Leukemia/Lymphoma
- ☐ Stroke
- ☐ Migraines
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Anxiety
- ☐ Anemia
- ☐ Mitral Valve Prolapse
- ☐ Liver Disease
- ☐ Varicose Veins
- ☐ Arthristis
- ☐ Cancer

Details: ____

____

35. Past Surgical History: (Check all that apply)

- ☐ Appendix
- ☐ Gall Bladder
- ☐ Incontinence Procedure
- ☐ Tonsillectomy
- ☐ Hernia
- ☐ Vasectomy
- ☐ Other

Details: ____

____

36. Have you had any complication with Anesthesia?

- ○ Yes
- ○ No

If yes, Please explain: ______________________________

____

37. Family Health History: (Check all that apply)

If any form of cancer: who and what age diagnosed? Other, please explain: ____

____

____

38.

Preventive Medical Visit Patient Information

Patient,

You are seeing your provider for a preventive medical visit. This is a comprehensive, preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures. Insurance carries may or may not provide coverage for screening laboratory and diagnostic studies; rules are carrier specific. Preventive medical visits are exempt from copayments.

If an abnormality is encounters or a pre-existing problem is address during the process of performing your preventive medical evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform key components of a problem-oriented evaluation and management service, then a separate office visit code may be charged. The use of this additional code will require a co-payment, coinsurance, or deductible if one is charged by your insurance plan.

If you have any questions regarding this matter, we advise you to contact your insurance carrier directly to discuss your coverage for these services.

New River Women's Health

I certify that I have read and understand the difference between preventive and problem-oriented visits and agree to pay the associated copay should the nature of my visit change.

Signature ____ Date: ________________

Printed Name: ____

At New River Health and Wellness, we provide different services ranging from annual exams, problem visits, lab tests, and imaging services. We unfortunately do not know the coverage for these services for each insurance company. We ask that you reach out to your insurance company if you have any specific questions regarding coverage, benefits, or payments that may be due. We also are happy to provide you with services, labs, or imaging at your request, but we do ask for the patient to take the responsibility of contacting your insurance company about coverage, eligibility, payments, etc.

Thank you for understanding.

Patient Signature: ____

Date: ____