Personal Data		
Name	Date	
Address	City State	Zip
Home Phone	Work Phone or Cell Phone	
Date of birth	Age	Blood Type
Current Height	Current Weight	Ideal Weight
Occupation		
Employer		
Marital Status		
Email		
How did you hear of us?		
Emergency Contact:	Name:	Phone Number:

Primary Care Physician		
Name	Phone	
Address	City State	Zip

As your cell phone and email are not considered “secure” communication devices:

Is it acceptable for us to contact you with medical information via e-mail? Yes / No

Is it acceptable for us to leave messages on a voice mail / answering machine for you? Yes / No

Patient Initials _______________

Present Symptoms

Please briefly describe your present symptoms/concerns.

Past Medical History

Please circle any conditions you have been diagnosed with and write the year of diagnosis.

Condition	Year	Condition	Year
Angina		Cancer	
Diabetes		If yes, what type of cancer?	
High Cholesterol		Enlarged Prostate	
High Blood Pressure		Gout	
Coronary Artery Disease			
Peripheral Artery Disease		Other:	

Past Surgical History

Please circle any surgeries you have had and write the year it occurred.

Surgery	Year	Surgery	Year
Hernia – L, R, bilateral		Spine	
Bypass – single, double, triple…		Prostate	
Stint Placement		Other:	
Penis (other than circumcision)			

Allergies

Please list all pharmaceutical allergies.

Medications:

Please list ALL prescription medications. (if you have a list with you we will gladly make a copy for your chart)

Prescription	Dosage	Dosing Schedule

Social History

Please remember that this information is strictly confidential.

Question		
Do you currently smoke cigarettes?	YES	NO
If yes, how many packs are you currently smoking per day?		
How many years have/did you smoked?		
Do you drink alcohol?	YES	NO
Have you used any illicit drugs within the last 24 hours	YES	NO
If yes, what illicit drugs?		

Urinary

Please answer the following questions

Question		
Have you been experiencing a frequent urge to urinate?	YES	NO
Have you experienced a decrease in the flow during urination?	YES	NO
Have you ever had kidney stones?	YES	NO
Have you noticed blood in your urine?	YES	NO
How many times a night to you wake up to urinate?		
When was the last digital rectal exam (DRE) performed on the prostate?		
When was the last PSA blood test performed?		

Cardiovascular

Have you been experiencing any of the following?

Condition		
High blood pressure	YES	NO
Low blood pressure	YES	NO
Arrhythmias or Papitations	YES	NO
Edema or swelling of your legs	YES	NO
Have you ever been diagnosed with a heart murmur?	YES	NO

Androgen Deficiency in the Aging Male Questionnaire Have you been experiencing any of the following in the past 5-10 years?		
Decrease in libido (sex drive)	YES	NO
Lack of energy	YES	NO
Decrease in strength and/or endurance	YES	NO
Loss of height	YES	NO
A decreased "enjoyment of life"	YES	NO
Increase is sad and/or grumpy feelings	YES	NO
Erections that are less firm	YES	NO
Recent deterioration in your ability to play sports or perform at the gym	YES	NO
Desire to fall asleep right after dinner	YES	NO
Recent deterioration in your work performance	YES	NO

Sexual Health and Performance Please answer Yes or No to the following questions		
Are you experiencing difficulties in achieving a full erection?	YES	NO
Are you experiencing difficulties in maintaining a full erection?	YES	NO
Are you experiencing early ejaculation issues?	YES	NO
Are you experiencing an inability to ejaculate?	YES	NO
Has the length of the penis decreased?	YES	NO
Has the girth of the penis decreased?	YES	NO

Sexual Health and Performance Medications and Therapies If you have ever used any of the following medications or techniques please share your results						
Medication			Dose	Results		
Cialis	YES	NO		Worked	Didn’t Work	So-So
Levitra	YES	NO		Worked	Didn’t Work	So-So
Viagra	YES	NO		Worked	Didn’t Work	So-So
Caverject	YES	NO		Worked	Didn’t Work	So-So
Tri-Mix	YES	NO		Worked	Didn’t Work	So-So
Boston Medical	YES	NO		Worked	Didn’t Work	So-So
Summit	YES	NO		Worked	Didn’t Work	So-So
Other:	YES	NO		Worked	Didn’t Work	So-So

ATTENTION: You are not aggreeing to purchase anything or commiting to a therapy by itiatialling and signing this paperwork. This is merely a doctor-patient arbitration agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Muse be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the doctors including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the doctor and the doctor's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the doctor to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the doctor, any fee dispute, whether or not subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each part shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share or the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or the expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of Arizona law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

→ **Patient Initials_____________** ←

CONTINUE TO PAGE 2 OF THIS DOCUMENT

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Arizona statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the Arizona Code of Civil Procedure provisions relating to arbitrations shall govern the arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the doctor within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: By signing this contract you are agreeing to have any medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article 1 of this contract.

By: ________________________________ → By: **X** ________________________________ ←
Doctor's or Duly Date **Patient's Signature** **Date**

________________________________ → ________________________________ ←
Print or stamp name of Doctor **Patient's Printed Name**

By: ________________________________ By: ________________________________
Signature of Translator (if applicable) Date Patient's Representative's Signature Date

________________________________ ________________________________
Print Name of Translator Print Name and Relationship to Patient

INFORMED CONSENT

I hereby permit Protea Medical Center and Dr. Brendan McCarthy, or his/her Associate Attending Physician of the same service, and assistants as may be selected and supervised by him/her to perform the following medical treatment, procedure or operation (hereafter the "procedure"):

- IV Therapy
- IM Administration
- Nutritional Consult
- Botanical Medicine
- Pharmaceutical Interventions
- Hormonal Therapy
- Regenerative Techniques
- Autologous Cellular Therapy

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure.

If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment that is necessary.

X ____

Signature of Patient **Date**

WITNESS:

I, ____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

____

Signature of staff member **Date**

Cancellation Policy

We understand that unexpected circumstances may arise from time to time. For the consideration of the physician's time, as well as other patients waiting to be seen, a $25 cancellation charge can be applied to appointments cancelled less than 24 hours before the appointment time. For your convenience, we have an answering machine available for messages after hours and on weekends. Thank you for your cooperation.

I have read and understand the Cancellation Policy.

X
____

Signature of Patient   Date

Credit Card on File

If you would like to expedite your checkout experience please fill in the following financial info.

Information provided is safely stored and protected.

Credit Card Type: AMEX   VISA   MAST   DISC

Card Number: _______________________________________

Expiration Date: ____________________

Security Code: ____________________

Name on card: ____

Patient Signature: **X**________________________________

Intracavernosal Injection Consent

This injection is not part of every office visit and we include this paperwork for office flow. Feel free not to sign this until meeting with the doctor and having had your questions answered.

The injected solution includes three vasodilators including papaverine, phentolamine and prostaglandin E1. These are well-understood medications and they will facilitate the dilation of the penile arteries leading to an increase in blood flow to the penis. This increase in blood flow will lead to a partial or full erection that typically lasts 40-60 minutes. In rare instances the application of these medication can lead to a priapism (erection lasting more than 3-4 hours) as well as penile discomfort or light-headedness.

I understand that I have been advised that I should not receive a test dose if I have the following conditions;

- Sickle Cell Anemia or Trait
- Leukemia
- Multiple Myeloma
- Penile Implant
- Peyronie's Disease
- Fabry Disease
- Malaria
- Uncontrolled Liver Disease (Hepatitis A, B, C)

By signing below you are acknowledging that you are not presently suffering from any of the above conditions.

By signing this consent form you are agreeing to any necessary treatment in the case of a priapism. The medical staff will treat the priapism to protect your safety at no extra cost.

By signing below you are acknowledging that you have not used marijuana, or recreational drugs such as cocaine, ecstasy, or heroin in the last 24 hours. I further acknowledge that I have not used Viagra, Levitra, Cialis or any other similar oral erectile dysfunction medications within the last 24 hours.

By signing below you are acknowledging to follow the physicians orders pertaining to the usage and safety recommendations of the medication.

I, (patient name) ____, fully understand the nature of the above tests and possible side effects. I consent to treatment by the doctor and his staff should I experience any inopportune symptoms.

Date: __________________________

Patient signature: **X** ____