MEN'S HEALTH AND WELLNESS

BETTY BOWERS M.D.

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WELCOME TO MEN'S HEALTH AND WELLNESS. THE MISSION OF THIS CLINIC IS TO HELP AN INDIVIDUAL ASSESS THEIR RISK FACTORS FOR DISEASE AND DEVELOP A PLAN TO AVOID THE POSSIBLE CONSEQUENCES. THIS CLINIC IS A PARTNERSHIP BETWEEN THE PATIENT AND PHYSICIAN. THE PATIENT IS GIVEN THE RESULTS OF THE EXAMINATION AND LABS ALONG WITH A PLAN DEVELOPED TO RESPOND TO THOSE FINDINGS. THE PATIENT IS THEN EMPOWERED TO USE THIS INFORMATION TO DETERMINE HIS OWN DESTINY.

THE PROCCESS BY WHICH THIS HAPPENS IS FOUR FOLD . FIRST A LENGTHY (SOME SAY ANNOYING) QUESTIONNAIRE IS FILLED OUT, PREFERABLY AT HOME WHERE YOU CAN LOOK UP INFORMATION THAT YOU HAVEN'T COMMITTED TO MEMORY. SECOND, YOU COME TO THE CLINIC WHERE WE WILL GO OVER YOUR QUESTIONNAIRE AND HAVE A COMPREHENSIVE WELLNESS EXAM. THE THIRD STEP IS TO HAVE AN EXTENSIVE LAB WORK UP WHICH MUST BE DONE BEFORE 10:00 AM WITH NOTHING TO EAT OR DRINK AFTER MIDNIGHT EXCEPT 3 GLASSES OF WATER IN THE MORNING. THE FINAL STEP IS TO RETURN TO THE CLINIC ONCE YOUR LAB WORK IS BACK AND HAS BEEN ANALYZED AND YOUR PLAN HAS BEEN DEVELOPED. THE FIRST AND SECOND VISITS ARE SCHEDULED FOR AN HOUR. WHEN WE GO OVER THE LAB RESULTS, YOU ARE WELCOME TO BRING A FAMILY MEMBER OR FRIEND WITH YOU.

THIS TYPE OF VISIT IS OUTSIDE OF WHAT INSURANCE COMPANIES FEEL IS NECESSARY, SO I HAVE BEEN FORCED TO GO TO A CASH SYSTEM. THE FEE SCHEDULE IS AS FOLLOWS:

NEW PATIENT VISIT IS $300.00
SECOND VISIT (1 HOUR) IS $180.00

FOLLOW UP VISITS ARE AS FOLLOWS:

BRIEF (15") IS $45.00
INTERMEDIATE (30") IS $90.00
EXTENDED (45') IS $135.00
COMPREHENSIVE (60") IS $180.00

THE LABS ARE EXTRA AND THERE IS THE OPTION OF FILING WITH YOUR INSURANCE COMPANY IF THEY ALLOW IT (MEDICARE DOES NOT) OR PAYING CASH, WHICH IS MORE COST EFFECTIVE IF YOUR INSURANCE WON'T PAY.

I LOOK FORWARD TO SEEING YOU.

Betty Bowers MD

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PH: (405) 753-9600 FAX: (405) 753-9601

NAME:_____

DOB:_____

SEX:_____

HOME PHONE:_____

WORK PHONE:_____

CELL PHONE:_____

E-MAIL_____

ADDRESS:_____

_____

_____

NEXT OF KIN:_____ PH:_____

RELATIONSHIP:_____ OK TO RELEASE INFORMATION? Y/N

NEXT OF KIN: _____ PH:_____

RELATIONSHIP: _____ OK TO RELEASE INFORMATION? Y/N

PHARMACY_____ PH._____

DO YOU WISH A COPY OF HIPPA GUIDELINES? Y/N

PatientName _____

Date of Birth _____

Health Habits History and Comprehensive Medical History

Circle YES or NO. If YES, indicate what % of time associated with that habit.

Do you wear seat belts?	Yes	No	%
Do you wear helmets for contact sports? (If you engage in contact sports)	Yes	No	%
Do you wear sun protection outside? (Sunscreen, Hats, Sunglasses)	Yes	No	%

Do you have a working smoke detector in your home?	Yes	No
Do you have a working carbon monoxide detector in your home?	Yes	No
Do you have a storm shelter with supplies?	Yes	No
Do you have a severe weather alert system?	Yes	No
Do you have an escape plan in case of fire?	Yes	No
Do you have architectural aspects of your home that limit you? (Stairs, etc)	Yes	No
Are you exposed to unhealthy substances at work?	Yes	No
Are you exposed to unhealthy substances with any hobbies?	Yes	No
Do you ever feel threatened for you safety at home?	Yes	No
Do you ever feel threatened for you safety at work?	Yes	No
Do you have difficulties with activities of daily living? (dressing, bathing, grooming, feeding, ambulating, etc.?)	Yes	No
Do you have difficulties with instrumental activities of daily living? (shopping, cooking, laundry, cleaning, bill paying, etc. ?)	Yes	No
Do you exercise regularly? If yes, please list types of exercise.	Yes	No

Tooth Care :

Brush teeth one time per day?	Yes	No	%
Brush teeth two times per day?	Yes	No	%
Floss daily?	Yes	No	%
Up to date on dental checkup? If yes, please list appropriate date.	Yes	No	Date:

Physical:

Do you have regular physical checkups?	Yes	No	Date:
Have you had any screening exams? (not listed below)	Yes	No	Date:
Do you do regular breast exams?	Yes	No	Date:
Have you had a colonoscopy	Yes	No	Date:
Have you had a prostate exam?	Yes	No	Date:
Have you had a TB test?	Yes	No	Date:
Have you had a routine blood screening?	Yes	No	Date:
Have you had any type of cancer screening?	Yes	No	Date:
Have you had a routine heart scan?	Yes	No	Date:

Do you know your immunization history?	Yes	No
Do you get routine recommended vaccinations?	Yes	No
Do you know the recommendations for adult vaccinations?	Yes	No

Social:

Do you have multiple sex partners?	Yes	No
Do you practice safe sex?	Yes	No
Do you smoke or have you ever smoked?	Yes	No
If you smoke, how many packs a day?		
If you smoke, for how many years:		
If you stopped smoking, when?	Date:	
Are you currently or have you ever been exposed to second-hand smoke?	Yes	No
If yes, number of years:		
Do you or have you ever used smokeless tobacco?	Yes	No
If you quit smokeless tobacco, when?	Date:	
If you currently use tobacco products, are you ready to quit?	Yes	No
Do you consume alcohol?	Yes	No
If yes, number of drinks per day:	Per day:	
Have you ever had so much to drink that you couldn't remember what you were doing?	Yes	No
Do you think you might need help?	Yes	No
Do you use recreational or street drugs?	Yes	No Never
If yes, when was the last time:	Date:	
Do you think you might need help?	Yes	No
Do you gamble?	Yes	No
If yes, is gambling causing financial stress?	Yes	No

LIST TOP TEN STRESSORS IN YOUR LIFE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

NUTRITIONAL HISTORY

Do you have any food sensitivities and/or allergies? YES NO

If Yes, please list below:

	FOOD	REACTION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

LIST YOUR FAVORITE FOODS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

LIST FOODS YOU STRONGLY DISLIKE:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

REGARDING GENERAL WELLNESS FOR MEN

Please score each of these symptoms as:	NONE	MILD	MODERATE	SEVERE	EXTREMELY SEVERE
Decrease in general feeling of well-being?					
Pain in joints or muscles?					
Excessive sweating with out exercising?					
Difficulty sleeping, getting to sleep or staying asleep?					
Problems with increased tiredness during the day?					
Been told that you snore?					
Irritable, grumpy or get upset easily?					
Feeling tense, restless or anxious?					
Physical exhaustion or lacking vitality?					
Decreased muscle strength or endurance?					
Have you lost height?					
Do you notice a decrease in work performance?					
Feel like you are getting old?					
Decrease in body hair or having to shave less frequently?					
Decrease in ability or frequency to perform sexually?					
Decrease in number of morning erections?					
Decrease in sexual desire or libido?					
Are your erections less strong?					
Are your ejaculations abnormal?					

Comprehensive Patient History
(Male)

Do you have or have you ever had any of the following? (Circle any that apply &/or fill in the blank. Give the approximate date of the event or diagnosis, if you can remember.)

Heart:

Heart Murmur	Yes	No
Irregular Heart Beat	Yes	No
PVC's	Yes	No
PAC's	Yes	No
Atria Fibrillation	Yes	No
PAT	Yes	No
Chest Pain or Angina	Yes	No
Heart Attack	Yes	No
Balloon dilatation of heart vessels	Yes	No
Heart Stent	Yes	No
Heart Surgery	Yes	No
Abnormal Heart Valve	Yes	No
Defibrillator	Yes	No
Pacemaker	Yes	No
Congestive Heart Failure	Yes	No
Carotid Artery Ultrasound	Yes	No
Carotid Artery Disease / Blockage	Yes	No
Carotid Artery Surgery	Yes	No

Other

None of the above

Blood Pressure Problems:

High Blood Pressure	Yes	No	If yes,	Treated	Untreated
Low Blood Pressure	Yes	No	If yes,	Treated	Untreated

Other

None of the above

Eye Problems:

Cataracts	Yes	No	If yes, surgery ?		Yes	No
Blindness	Yes	No	If yes,		Right	Left
Glaucoma: (high pressure in eye)					Yes	No
If yes,					Right	Left
Trauma	Yes	No	If yes,		Right	Left
Detached Retina	Yes	No	If yes,		Right	Left
Artificial Eye	Yes	No	If yes,		Right	Left
Bleeding in Eye	Yes	No	If yes,		Right	Left
Cancer:	Yes	No	If yes,	Treated		Untreated

If treated, how?

Other

None of the above

Kidney Problems:

Bladder Intections	Yes	No
Kidney Infections	Yes	No
Kidney Stones	Yes	No
Congenital Kidney Abnormalities	Yes	No
Removal of Kidney for disease or Trauma	Yes	No
Kidney Failure	Yes	No
May need dialysis in future	Yes	No
Dialysis :	Yes	No
If yes, type of dialysis	Hemodialysis	or Peritoneal
Have Shunt:	Yes	No
Where:		

Other

None of the above

Lung Problems:

Shortness of Breath	Yes	No			
Asthma	Yes	No			
Wheezing	Yes	No			
Daily Cough:	Yes	No	If yes,	Productive	Dry
Bronchitis	Yes	No			
Pneumonia	Yes	No			
COPD	Yes	No			
Emphysema	Yes	No			
Water on Lungs	Yes	No			
Sleep Apnea: C-PAP machine at night	Yes	No			
Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Exposure to TB	Yes	No

Other

None of the above

Liver Disease

Large Liver	Yes	No			
Yellow Jaundice	Yes	No			
Chronic Hepatitis	Yes	No			
Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Other

None of the above

Neurologic:

Dizziness/Blackout Spells	Yes	No
Headaches	Yes	No
Trauma to Brain	Yes	No
Seizures	Yes	No
Hydrocephalus	Yes	No
VP Shunt	Yes	No
Stroke	Yes	No
Brain Tumor	Yes	No
Trouble Swallowing	Yes	No
Trouble with Speech	Yes	No
Depression	Yes	No
Numbness:	Yes	No

If yes, where?

Paralysis:	Yes	No

If yes, where?

Weakness of Arms/Legs	Yes	No
Congenital/Acquired Muscle Disease	Yes	No

Other

None of the above ☐

Thyroid Problems:

High Thyroid	Yes	No	If yes,	Treated	Untreated
Low Thyroid	Yes	No	If yes,	Treated	Untreated

Weight Gain	Yes	No
Trouble breathing because of thyroid	Yes	No
Thyroid Related Eye Problems	Yes	No

Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Other

None of the above ☐

Diabetes:

Diagnosed with Diabetes	Yes	No

If yes, how long?

Diet Controlled	Yes	No
On Insulin or Oral Medication	Yes	No
Ulcers on Feet or Legs	Yes	No
Amputation of Feet or Legs	Yes	No
Surgery for blood vessel Disease of legs	Yes	No
Peripheral Neuropathy	Yes	No
Numbness/Stinging/Burning of Feet or Legs	Yes	No
Disease of Eyes Secondary to Diabetes	Yes	No

Other

None of the above ☐

Digestive Problems:

Frequent Heartburn	Yes	No
GERD	Yes	No
Hiatel Hernia	Yes	No
Motion Sickness	Yes	No
Stomach Ulcers	Yes	No
Black Tarry Stools/Blood in Stools	Yes	No

Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Other

None of the above ☐

Muscular/Skeletal Problems:

Congenital Muscle Disease	Yes	No
Acquired Muscle Disease	Yes	No

Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Trouble Opening Mouth	Yes	No
Jaw Problems	Yes	No
Neck Problems	Yes	No
Problems with Shoulders	Yes	No
Back Problems	Yes	No
Problems with Legs	Yes	No
Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No
Trouble Swallowing	Yes	No
Total Joint Replacement:	Yes	No

If yes, where?

Cancer:	Yes	No	If yes,	Treated	Untreated

If treated, how?

Other

None of the above ☐

Blood Problems:

Bruise or Bleed Easily	Yes	No
Anemia / Low Blood	Yes	No
Blood Transfusions	Yes	No
Abnormal Hemoglobin	Yes	No
Blood Clots	Yes	No
Blood Infections / Sepsis	Yes	No
Sickle Cell Disease / Trait	Yes	No
HIV Virus	Yes	No
AIDS	Yes	No
Leukemia	Yes	No

Other _____

None of the above ☐

Do you have or use any of the following:

Dentures	Yes	No
Loose Teeth	Yes	No
Temporary Crowns	Yes	No
Partial Plate	Yes	No
Removable Bridge	Yes	No
Contact Lenses	Yes	No
Hearing Aid	Yes	No
Body Piercing	Yes	No
Tattoos	Yes	No

Other _____

None of the above ☐

Males:

Prostate Problems Yes No

Prostate Cancer: Yes No If yes, Treated Untreated

If treated, how?

Breast Cancer: Yes No If yes, Treated Untreated

If treated, how?

Other _____

None of the above ☐

Current Medications: (Prescriptions, Supplements or Over the Counter)

Medication	Dose	How often do you take it?

Allergies:

Medication Type of Reaction

Food Type of Reaction

Latex Yes | No Type of Reaction

Family History:

Do any diseases run in your family? Yes | No

If yes please explain:

Testing: **Date of last test:** **Where was it done?**

EKG - Yes | No

Blood work - Yes | No

Hospitalizations:

Surgery and Anesthetic History:

Surgery Performed	Date of surgery (Approximate)	Complications (Explain)

Concerns:

Is there anything specific you would like to discuss at your visit? YES NO

Describe:

INFORMATION FOR MEN CONSIDERING TESTOSTERONE REPLACEMENT THERAPY

1.COMMON PRESENTING SYMPTOMS OF TESTOSTERONE DEFICIENCY ARE FATIGUE, DECREASED LIBIDO, LACK OF MORNING ERECTIONS, DECREASED STRENGTH OF ERECTIONS, INCREASED ABDOMINAL FAT DEPOSITS, DECREASED ABILITY TO FOCUS, FORGETFULNESS, AND DECREASED AMBITION AND MOTIVATION .

2.CONSEQUENCES OF UNCORRECTED LOW TESTOSTERONE LEVELS INCLUDE INSULIN RESISTANCE OR PRE-DIABETES, IMPAIRED CARBOHYDRATE METABOLISM, WEGHT GAIN, OSTEOPENIA/OSTEOPOROSIS, LOSS OF MUSCLE MASS AND STRENGTH, LOSS OF COGNITIVE FUNCTION, DECREASE IN MOTIVATION AND DRIVE, INCREASED ANXIETY AND DEPRESSION, DECREASED ABILITY TO CONCENTRATE, INCREASED RISK OF DISEASES OF AGING AND DECREASE IN OVERALL QUALITY OF LIFE.

3.BENEFITS OF TESTOSTERONE REPLACEMENT THERAPY (TRT) INCLUDE AN ANTI-INFLAMATORY EFFECT, WHICH DECREASES THE FORMATION OF ATHEROSCLEROTIC PLAQUES AND IMPROVES SYMPTOMS OF AUTOIMMUNE DISEASES. TESTOSTERONE IS A VASODIALATOR THAT CAN IMPROVE THE SYMPTOMS OF ANGINA AND CLAUDICATION (SEVERE LEG PAIN CAUSED FROM INSUFFICIENT BLOOD SUPPLY TO THE MUSCLE FROM HARDENING OF THE ARTERIES). TRT DECREASES FAT DEPOSITION AROUND THE INTERNAL ORGANS. THIS FAT PRODUCES DANGEROUS HORMONES. TRT DECREASES THE CHANCE OF BLOOD CLOTS. TRT IMPROVES INSULIN SENSITIVITY, WHICH HELPS CONTROL THE BAD CHOLESTEROLS. IT IMPROVES BONE HEALTH BY TREATING AND PREVENTING OSTEOPAROSIS. TRT PRESERVES BRAIN FUNCTION AND VITALITY. TESTOSTERONE IS CRITICAL IN MAINTAINING NORMAL PENILE ARCHITECTURE AND BLOOD SUPPLY. TRT HELPS MAINTAIN NORMAL BODY COMPOSITION BY MAINTAINING LEAN BODY MASS AND MUSCLE STRENGTH AND DECREASING FAT DEPOSITS. TRT REGULATES CARBOHYDRATE METABOLISM, WHICH DECREASES THE CHANCE OF DIABETES. TRT ALSO IMPROVES MOOD AND PROMOTES A FEELING OF WELL BEING.

4. THERE ARE POTENTIAL SIDE EFFECTS TO TRT. TRT CAN STIMULATE GROWTH OF THE PROSTATE, WHICH COULD RESULT IN DIFFICULTY PASSING URINE. IT STIMULATES THE BONE MARROW TO PRODUCE RED CELLS, WHICH CAN RESULT IN THICKENING OF THE BLOOD, WHICH CAN INCREASE THE RISK OF A STROKE. IT CAN CAUSE BREAST TENDERNESS ESPECIALLY IF THE BODY METABOLISES TESTOSTERONE INTO ESTROGEN. IT IS THOUGHT TO INCREASE THE RISK OF APNEIC EPISODES IN PATIENTS WITH, OR AT RISK FOR, SLEEP APNEA. TRT CAN SUPPRESS SPERM PRODUCTION SO CAUTION NEEDS TO BE TAKEN IF THE PATIENT HAS NOT HAD CHILDREN YET. IT CAN ALSO RESULT IN TESTICULAR ATROPHY. OTHER SIDE EFFECTS LISTED ARE LIVER PROBLEMS, DECREASED WHITE CELL COUNT, HIVES, MUSCLE SPASM, NAUSEA AND VOMITTING, INSOMNIA, ANXIETY, HEADACHES, HYPERLIPIDEMIA, PROLONGED ERECTIONS, HYPERTENSION, TACHYCARDIA AND INJECTION SITE IRRITATION.

5.THERE ARE SEVERAL FORMS OF TESTOSTERONE USED FOR REPLACEMENT THERAPY. TROCHES ARE AN ORALLY ABSORBED FORM OF TESTOSTERONE, WHICH CAN ALTER TASTE AND CAN CAUSE GUM IRRITATION AND HAS UNPREDICTABLE ABSORPTION. TESTOSTERONE TOPICAL PREPARATIONS HAVE A POTENTIAL RISK OF

TRANSFERRING THE TESOSTERONE TO A PARTNER OR CHILDREN WITH SKIN TO SKIN CONTACT AND IT TOO CAN HAVE VARIABLE ABSORPTION. TESTOSTERONE PATCHES HAVE SIMILAR ISSUES. ORAL TESTOSTERONE IN PILL FORM HAS A HIGHER RISK OF LIVER IMPAIRMENT. INTRAMUSCULAR TESTOSTERONE ADMINISTRATION CAN CAUSE DISCOMFORT AT THE INJECTION SITE AND RARELY A HEMATOMA OR INFECTION. TESTOSTERONE PELLETS ARE IMPLANTED SUBCUTANEOUSLY AND CARRY A RISK OF BRUISING, INFECTION AND EXTRUSION.

6.CONTROVERSY EXISTS OVER TESTOSTERONE REPLACEMENT THERAPY. THE MAIN CONTROVERSY IS OVER WHETHER TRT INCREASES THE RISK OF PROSTATIC CANCER. THE EFFECTS OF TESTOSTERONE ON PROSTATE CANCER HAVE NOT BEEN FULLY RESOLVED.. IT IS WIDELY ACCEPTED THAT THERE ARE NO STUDIES SHOWING THAT TESTOSTERONE INCREASES THE RISK OF PROSTATE CANCER. THERE ARE ONGOING STUDIES ON THIS SUBJECT. THERE IS EVEN SOME QUESTION AS TO WHETHER TESTOSTERONE MAY PREVENT PROSTATE CANCER. ON GOING STUDIES WILL, HOPEFULLY, SHED MORE LIGHT ON THIS ISSUE. SINCE TESTOSTERONE REPLACEMENT IS SO BENEFICIAL IN DECREASING THE DEVELOPMENT OR WORSENING OF CHRONIC DISEASE PROCCESSES AND IMPROVING THE QUALITY OF LIFE, THE RISKS ARE CONSIDERED ACCEPTABLE WITH CLOSE MONITORING FOR CANCER USING REGULAR PSA TESTING AND REGULAR VISITS WITH ONES PCP OR UROLOGIST. ALSO, IT IS IMPORTANT TO FOLLOW LABS THAT WATCH FOR THE POTENTIAL SIDE EFFECTS OF TESTOSTERONE AND MAKE SURE THAT PATIENTS MAINTAIN A SAFE THERAPEUTIC BLOOD LEVEL.

7. THERE ARE CONTRAINDICATIONS, BOTH RELATIVE AND ABSOLUTE, TO TRT SUCH AS MEN DIAGNOSED WITH BREAST CANCER, MEN WHO HAVE HEART DISEASE SEVERE ENOUGH TO LIMIT ACTIVITY OR ANY DISEASE THAT RESTRICTS PHYSICAL ACTIVITY, AND PATIENTS WITH METASTATIC PROSTATE CANCER. RELATIVE CONTRAINDICATIONS ARE PROSTATE CANCER CONFINED TO THE PROSTATE IF THE PATIENT'S ONCOLOGIST AGREES, MEN WITH A CONDITION CALLED POLYCYTHEMIA AND PATIENTS WHO ARE MORBIDLY OBESE WITH LOW TESTOSTERONE SECONDARY TO THEIR BODY TURNING TESTOSTERONE INTO ESTROGEN. ONE SHOULD ALSO ADD MEN WHO WANT TO HAVE CHILDREN AS A RELATIVE CONTRAINDICATION.

8. PATIENTS WHO ARE ON TRT ALSO NEED TO BE RESPONSIBLE FOR CERTAIN ASPECTS OF THEIR CARE. THEY NEED TO TAKE THEIR MEDICATION AS DIRECTED, START A REGULAR EXERCISE PROGRAM, EAT A BALANCED DIET, USE RECOMMENDED SUPPLIMENTS AND FOLLOW THROUGH ON REGULAR EXAMS AND BLOOD WORK.