MEN'S HEALTH AND WELLNESS

BETTY BOWERS M.D.
13313 N. MERIDIAN SUITE A-3
OKLAHOMA, CITY, OK 73120
PH: (405) 753-9600 FAX: (405) 753-9601

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:

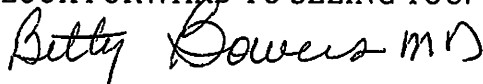
- NEW PATIENT VISIT IS $300.00
- SECOND VISIT (1 HOUR) IS $180.00

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.



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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

Patient Name:____________________

Date of Birth:____________________

(Female)

Health Habits History and Comprehensive Medical History

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

Question			
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:

Question			
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:

Question			
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 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	Date:
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. ______

Comprehensive Patient History
(Female)

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: ____________________

Condition		
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: ____________________

Condition					
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: ____________________

Condition					
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: ____________________

Condition		
Bladder Infections	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	Peritoneal
Have Shunt:	Yes	No

Where: ____________________

Other ____________________

None of the above ☐

Lung Problems:

Condition					
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? ____________________

Condition		
Exposure to TB	Yes	No

Other ____________________

None of the above ☐

Liver Disease ____________________

Condition					
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 or 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 ☐

GU:

Females:

Last Menstrual Period	Date:		
Could you be pregnant?	Yes	No	
Tubal ligation	Yes	No	
If yes, when?			
Hysterectomy	Yes	No	
If yes, when?			
Ovaries Removed	Yes	No	
If yes,	Right	Left	Both
Hot Flashes	Yes	No	
Vaginal Dryness	Yes	No	
Frequent Unary Tract Infection	Yes	No	
Abnormal Hair Growth	Yes	No	

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: