PATIENT REGISTRATION & MEDICAL HISTORY:

Last Name: _____ First Name & MI: _____ Sex: M / F

DOB: _____ Social Security #: _ _ _-_ _- _ _ _ _

Phone #:_____ Email Address: _____

Address: _____
Street City, State, Zip

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Phone #: _____

INDIVIDUAL PHI RELEASE

The following individuals may have information regarding my treatment without restriction:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

The above information is true to the best of my knowledge. I authorize the release of records to my insurance company listed for claims purposes and insurance benefits to be paid to Helix Health. I understand I am financially responsible for any balance. I understand the privacy policies in place at Helix Health. I understand that I can request a copy of those policies at any given time.

Patient Signature: _____ Date: _____

How did you hear about Helix Health? _____

HELIX HEALTH – 2210 W. Kingshighway Suite 7 | Paragould, AR 72450 | 870.236.2911

Any known drug allergies: _____

Have you ever had anesthesia? Yes or No

If yes, please explain: _____

Current medications:

_____

Current/Past Hormone Replacement: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when:

_____

Other Pertinent Information: _____

PLEASE CIRCLE ALL THAT APPLY:

High Blood Pressure
High Cholesterol
Heart Disease
Stroke and/or heart attack
Blood clot and/or pulmonary emboli
Hemochromatosis
Depression/Anxiety
Psychiatric Disorder
Cancer (type): _____ & Year
Testicular/Prostate Cancer: Treated? & Year ____
Elevated PSA
Prostate Enlargement
Trouble Urinating or Taking Flomax or Avodart
Chronic Liver Disease (Hepatitis, Fatty Liver, Cirrhosis

Prostate Cancer
Prostate Cancer Treated
Recent Urological Workup
Currently on Thyroid Med
Hashimoto's Thyroiditis
Migraine Headaches
Currently on HRT
Trying to conceive
Diabetes
Thyroid Disease
Arthritis

PLEASE CIRCLE ALL THAT APPLY:

Social History:

- I am sexually active
- I have completed my family
- I am trying to conceive
- I have used steroids in the past for athletic purposes
- I smoke _____ a day
- I drink alcoholic beverages _____ drinks, _____ times per week
- I use caffeine _____cups per day

How often do you exercise?

0 hours () 1-3 hours/wk. () 4-7 hrs./wk. () >8 hr./wk. ()

Symptoms:

Fatigue
Joint Pain
Sleep Problems
Irritability Anxiety/Nervousness
Depressive Mood
Declining Mental Ability/Focus
Decreased Muscle Strength
Weight Gain
Decreased Desire/Libido
Decreased Morning Erection

Family History:

Heart Disease
Diabetes
Osteoporosis
Alzheimer's Disease