Vitalize

A Center For MEdical Revitalization

Date_____

Dear_____

Your appointment at Vitalize Medical Center is scheduled

for_____ at _____

Please fill out the enclosed information sheet and bring it with you to your appointment.

If you have any questions, please call us at (585)287-5299.

We look forward to meeting with you.

The Staff at Vitalize

980 Westfall Road ■ Building 100 ■ Suite 110 ■ Rochester, NY 14618
585-287-5299 ■ Info@VitalizeMedical Center.com ■ www.VitalizeMedicalCenter.com

Vitalize
A CENTER FOR MEDICAL REVITALIZATION

Office Financial Policy

1) **24 hour cancellation notice is required or you will be charged the full consultation fee for the missed appointment.**

2) This office does not accept insurance; however, we will provide you with the appropriate diagnosis codes for you to submit to your insurance. If you have any questions regarding coverage please check with your insurance company.

3) All payments are due at time of service.

4) The consultation fee for your initial visit with Dr. Ralph Madeb is **$250**.
Follow-up visits with Dr. Madeb and/or the staff and any additional rounds of treatments are subject to additional payments.

5) Any recommended supplements and/or lab fees are not included in the above

6) Our office accepts: Cash, Checks, Money Orders, and all Major Credit Cards

7) There will be $35.00 fee for all returned checks

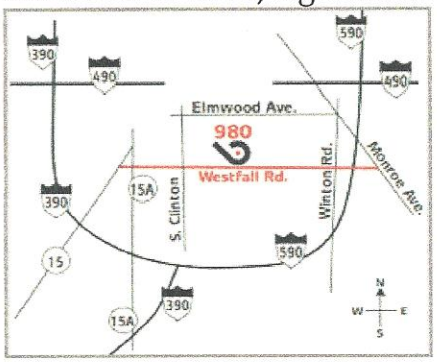
Driving Directions

From East: 490-W to 590-S to Monroe Ave. (exit 2A); Left onto Monroe, Right onto Westfall Road

From West: 490-E to 390-S to East Henrietta Road (exit 16B); Left onto EHR, Right onto Westfall Road

From North: 390-S to East Henrietta Road (exit 16B); Left onto EHR, Right onto Westfall Road. 590-S to Monroe Ave. (exit 2A); Left onto Monroe Ave, Right onto Westfall Road

From South: 390-N to Rt. 15A/East Henrietta Road; Right onto EHR, Right onto Westfall Road



980 WESTFALL ROAD ■ BUILDING 100 ■ SUITE 110 ■ ROCHESTER, NY 14618
585-287-5299 ■ INFO@VITALIZEMEDICAL CENTER.COM ■ WWW.VITALIZEMEDICALCENTER.COM

Vitalize
A CENTER FOR MEDICAL REVITALIZATION

WELCOME TO VITALIZE MEDICAL CENTER!

Through our desire to provide you with the most focused and personalized healthcare experience, we would like to understand the primary reason that has brought you to the center today. Please take a moment to identify which of the following you are hoping to achieve through your care at our center.

(Please circle all that apply.)

Improved Energy Improved Physical Stamina/Endurance

Increase in Sex Drive Improved Sexual Function Weight Loss

PATIENT INFORMATION

How did you hear about our clinic?_____

Last Name_____ First Name_____ M Initial_____

Address_____

City/St/Zip_____

Home Phone_____ Cell_____

Date of Birth_____ Age_____ SS_____

Height_____ Weight_____

Primary Care Physician (PCP)_____

Preferred method of contact_____

Email_____

Employer_____ Work Phone_____

Work Address_____ City/State/Zip_____

May we send you a text message reminder the day before your appointment? (Circle One) YES NO

(We will not send you any other text messages without prior approval.)

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____

Vitalize

A CENTER FOR MEDICAL REVITALIZATION

Lifestyle Factors

WORK Occupation	How many hours per week do you work?
HOME If you have kids, list their names, ages, and genders here	Do any of your family members have special needs? If so, who? Describe their situation.
Marital Satus:	

PHYSICAL ACTIVITY Type			Duration Hours / Minutes
Intensity ☐ Low ☐ Moderate ☐ High	Frequency (times/week)	Are you consistent? ☐ Yes ☐ No	Regardless of your exercise program, are you sedentary for most of the day? ☐ Yes ☐ No

SLEEP Average hours of sleep per night	Do you awake feeling well rested? ☐ Yes ☐ No

Do you often have trouble falling asleep? ☐ Yes ☐ No	Do you have sleep apnea? ☐ Yes ☐ No ☐ Unsure	If you have sleep apnea, is it being treated? ☐ Yes ☐ No
Do you wake up at night? ☐ Yes ☐ No How many times?	If you know why, please explain.	

STRESS Do you have an unusually high amount of stress in your life? ☐ Yes ☐ No ☐ Sometimes
Do you have appropriate outlets for coping & dealing with stress? ☐ Yes ☐ No ☐ Sometimes

Describe your current stress-reduction methods (such as mediation, yoga, breathing).	Most of your stress is due to what?

Personal Medical History

Please check all that apply to you:

Endocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Adrenals
- ☐ Pituitary
- ☐ Other_____

Mental Concerns
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Bipolar
- ☐ Substance Abuse
- ☐ Alcoholism
- ☐ Other_____

Cardiac Concerns
- ☐ Subsets of Heart Attack
- ☐ Angina
- ☐ Arrhythmia
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Other_____

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Pulmonary Emboli
- ☐ Blood Clots
- ☐ Other_____

Genitourinary
- ☐ Kidney Stones
- ☐ Impotence
- ☐ Infertility
- ☐ Menopause
- ☐ Fibroids
- ☐ Ovarian Cysts
- ☐ Polycystic Ovarian Syndrome
- ☐ Endometriosis
- ☐ Other_____

Cancer

Where _____

What Kind _____

When _____

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Back or Spine Problems
- ☐ Carpal Tunnel Syndrome
- ☐ Other_____

Gastrointestinal
- ☐ Ulcers
- ☐ Malabsortion
- ☐ Diverticulosis
- ☐ Hepatitis/Liver Disease
- ☐ Lactose Intolerance
- ☐ Other_____

Neurology
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Stroke
- ☐ Other_____

General
- ☐ Glaucoma
- ☐ Epstein Barr
- ☐ Chronic Fatigue Syndrome
- ☐ Other_____

Do you smoke? ☐ Yes ☐ No	If yes, what type?	If yes, how much (how often, how many)?	Do you want to quit? ☐ Yes ☐ No ☐ Unsure
Do you drink alcohol? ☐ Yes ☐ No	If yes, how many drinks do you have a week?	What do you drink?	
Do you drink caffeine (coffee, tea, soda drinks)? ☐ Yes ☐ No	If yes, how many drinks each day?		
Date of last Physical?	Date of last PSA/prostate exam?		

980 WESTFALL ROAD ■ BUILDING 100 ■ SUITE 110 ■ ROCHESTER, NY 14618
585-287-5299 ■ INFO@VITALIZEMEDICAL CENTER.COM ■ WWW.VITALIZEMEDICALCENTER.COM

Vitalize
A CENTER FOR MEDICAL REVITALIZATION

SURGERIES/HOSPITALIZATIONS

Year	Reason

MAJOR INJURIES OR ILLNESSES

Year	Reason

Family Medical History

Please list family members who currently have/had in the past any of the following: use the following abbreviations: Mother (M), Father (F), Sister (S), Brother (B), Maternal (MAT), Paternal (P), Grandmother (GM), Grandfather (GF), Aunt (A), Uncle (U):

High Blood Pressure:	Glaucoma:	Ovarian Cancer:	Dementia or Alzheimer's Disease:
Heart Attack/Age:	Muscular Degeneration:	Other Cancer:	Celiac disease
Stroke/Age:	Osteoporosis:	Depression:	Thyroid disorder
Blood Clots:	Hip Fracture:	Bipolar/Manic Depression:	Other:
Bleeding Tendency:	Breast Cancer:	Alcohol Abuse:	
Diabetes:	Colorectal Cancer:	Substance Abuse:	

Medication Log

MEDICATION AND NUTRITIONAL SUPPLEMENT UTLIZATION
Please list the name(s), dosage, frequency and duration of all medications your are taking:

1. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
2. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
3. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
4. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
5. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
6. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
7. Name:_____ Dosage:_____ Frequency:_____ How Long?_____
8. Name:_____ Dosage:_____ Frequency:_____ How Long?_____

If you need additional space please use back of form.

980 WESTFALL ROAD ■ BUILDING 100 ■ SUITE 110 ■ ROCHESTER, NY 14618
585-287-5299 ■ INFO@VITALIZEMEDICAL CENTER.COM ■ WWW.VITALIZEMEDICALCENTER.COM

Vitalize
A Center For MEdical Revitalization

Patient History Questionnaire (circle Yes or No)

Yes No Have you had any muscle weakness, fatigue or loss of muscle mass?

Yes No Has your interest in sex (libido) declined?

Yes No Do you have spontaneous erections (without medication or other aid)?

Yes No Has your energy level or stamina declined?

Yes No Have you lost self confidence, motivation or initiative?

Yes No Has there been any decline in memory or concentration ability?

Yes No Have you had any sleep disturbance or problems breathing while asleep?

Yes No Do you have mood swings or depression?

Yes No Have you noticed any increase in aggressiveness?

Yes No Do you have any breast tenderness or enlargement?

Yes No Have you lost any hair in the genital or underarm areas?

Yes No Has your need to shave decreased?

Yes No Have you noticed any significant change in the size of your testicles?

Yes No Do you have periodic hot flashes or sweats?

Yes No Have you ever had problems achieving a pregnancy?

Yes No Are you considering having any (or more) children?

980 Westfall Road ■ Building 100 ■ Suite 110 ■ Rochester, NY 14618
585-287-5299 ■ Info@VitalizeMedical Center.com ■ www.VitalizeMedicalCenter.com

Vitalize
A Center For MEdical Revitalization

Past History (circle Yes or No)

Yes No Have you ever had an abnormal PSA test or prostate exam?

Yes No Do you have or have you ever had thyroid disease, diabetes, high blood pressure, asthma/lung disease, acne, dry or oily skin, or any venereal disease?

Yes No Do you have any allergies to any medications? If yes, list on back of page.

Yes No Do you take any medications on a daily basis? If yes, list on back of page.

Yes No Have you ever had any surgery in the prostate or genital area?

Family History (circle Yes or No)

Yes No Do you have any blood related family members with breast cancer?

Yes No Do you have any blood related family members with prostate cancer?

Yes No Do you have any blood related family members with diabetes?

Yes No Do you have any blood related family members with cardiovascular disease?

Social History (circle Yes or No)

Yes No Do you use tobacco? If yes, how much? _____

Yes No Do you drink alcoholic beverages? If yes, how much? _____

Patient Signature _____ Date _____

980 Westfall Road ■ Building 100 ■ Suite 110 ■ Rochester, NY 14618
585-287-5299 ■ Info@VitalizeMedical Center.com ■ www.VitalizeMedicalCenter.com

Vitalize
A CENTER FOR MEDICAL REVITALIZATION

Consent for Evaluation & Treatment of Medical Program

I authorize and give my Consent to Vitalize Medical Center and its Medical Doctors, and such other physicians, associates, technicians, as well as any other health care personnel of Vitalize Medical Center for the evaluation and treatment of my Medical Weight Loss and/or Hormone Therapy Program by the administration of prescribed medication while under the supervision of Vitalize Medical Doctors.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure, treatment and therapy; including the proposed treatment for Medical Weight Loss and/or Hormone Therapy and that it is not possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known and unknown general risks.

I appreciate, understand, and agree to follow the proposed treatment and therapy as prescribed by Vitalize Medical Center Doctors without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or other designated therapies that may be prescribed to me possibly more than once daily. Furthermore I consent to periodically have my blood drawn, saliva acquired, or urine specimens obtained for laboratory monitoring and analysis as required by Vitalize Medical Center Doctors.

I also agree to take the medical weight loss, dietary supplements, hormone preparations, and other designated therapies on the schedule that has been individually provided to me, as prescribed specifically in detail. I have completely and faithfully disclosed my complete medical history, all prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over the counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to you. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from you, before stopping any of the prescribed therapeutic regimens or taking any additional preparations by you.

I also understand that the use of "social substances" such as tobacco, "street drugs," and alcohol and other types of otherwise non-described "social substances" may affect my therapy in a significantly adverse manner or way.

I also understand that Vitalize Medical Center does not bill insurance however they will for the Patients benefit, submit my given insurance to the required laboratories for testing and any medication perscribed. Vitalize Medical Center is not responsible for insured services rendered. I hereby state my understanding of my sole responsibility with any and all unpaid balances should they arise from my insurance company.

By signing this, I release Vitalize Medical Center of any and all liability. I confirm that I have read this form in its entirety or it has been read to me if I have been unable to read it, and understand there are risks associated with participating in any program offered by Vitalize Medical Center

Patient Name _____ Date _____

980 WESTFALL ROAD ■ BUILDING 100 ■ SUITE 110 ■ ROCHESTER, NY 14618
585-287-5299 ■ INFO@VITALIZEMEDICAL CENTER.COM ■ WWW.VITALIZEMEDICALCENTER.COM