GLORY WELLNESS CENTER & WEIGHT LOSS CLINIC

Dr. David Ikudayisi – Medical Director **FOR MEN**

Personal Data		
Name	Date	
Address	City State	Zip
Home phone	Work phone Cell phone	
Date of birth	Age	
Email		
Primary Care Physician		
Name	Phone	
Address	City State	Zip

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

Past Surgical History

Date	Surgery

Medications: Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC)

Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? _____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? _____

Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had elevated PSA? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a prostrate biopsy?		

Do you have a history of any of the following cancers:

☐ Lung ☐ Skin ☐ Other: _____
☐ Breast ☐ Lymphoma _____
☐ Colon ☐ Leukemia
☐ Prostate

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

Check which of these symptoms are troublesome and have persisted over time

☐ Low Libido
☐ Lack of Energy
☐ Decreased Strength/Energy
☐ Lost Height
☐ Decreased Enjoyment of Life
☐ Sad or Grumpy
☐ Problem with Memory/Concentration
☐ Decreased Erections
☐ Decreased Ability to Play Sports
☐ Fall Asleep After Dinner
☐ Sleep Disturbances
☐ Recent Deterioration of Work Performance
☐ Decreased Muscle Mass
☐ Hair Loss

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess		Cortisol Deficiency
☐ Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain – Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/Pains
☐ Memory Lapses	☐ Nervous	

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice has become hoarse	☐ Constipation
☐ Heart Palpitations	☐ Fatigued/Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a persistent cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema or sleep apnea?			

System Review – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition? Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes:

Patient SOAP Notes Form

Patient Name	Date B/P: P: WT:
Reason for Visit	Type of Visit ☐ Initial ☐ Follow-Up ☐ Final

Tests Ordered or Received

	Ordered	Received
CBC		
Skin Tests		
PFT		
Radiology		

Request Medical Records ☐ Yes

Review of Records:

Subjective Data (Symptoms/Content)

Objective Data (Observation/Labs)

Assessment/Diagnosis or Impression	Code

Plan / Medications

Follow-Up Days ☐ Weeks ☐ Months ☐ PRN ☐

Signature

Time In AM ☐ PM ☐ Time Out AM ☐ PM ☐

David Ikudayisi, M.D.

Total Time:_____

Disclosure / Liability Waiver

Glory MedClinic, LLC d/b/a Glory Wellness Center & Weight Loss Clinic – Bio-Identical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Glory MedClinic, LLC. It's staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____

Signature of Patient Date

_____ _____

Print Name Date

Consent for Hormone Supplementation Therapy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the physicians of **Glory MedClinic LLC, d/b/a Glory Wellness Center & Weight Loss Clinic.** I acknowledge that there are no guarantees or assurances made with respect to the benefit or hormone supplementation therapy prescribed for me.

I understand that I will be in charge of injecting/ administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the physician is for hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understood all of the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

I accept all terms and conditions of this program.

Signature of Patient_____ Date_____

Patient Name_____ Date_____

Physician Signature_____ Date_____