Riley Perry Lloyd, MD, FACOG

DATE:_____

HOW WOULD YOU LIKE TO BE ADDRESSED BY THE STAFF: _____

NAME: _____ _____/_____/_____
FIRST INITIAL LAST D.O.B.

STREET:_____ #_____

CITY:_____ STATE:_____ ZIP CODE:_____

(_____)_____ (_____)_____
PATIENT TELEPHONE W/ AREA CODE WORK TELEPHONE W/ AREA CODE

EMAIL: _____ @ _____

_____ _____
OCCUPATION EMPLOYER

PLEASE CIRCLE: SINGLE LIFE PARTNER MARRIED SEPARATED DIVORCED WIDOW

REFERRED BY: _____

_____ _____
EMERGENCY CONTACT NAME RELATIONSHIP TO PATIENT

(_____)_____
AREA CODE & TELEPHONE OF EMERGENCY CONTACT

4905 Old Orchard Center, Suite #330
Skokie, IL 60077

Phone: 847.763.7100 | Fax: 847.763.7102

Be Well Family Care
11495 N. Pennsylvania Street, Suite #270
Carmel, IN 46032

Patient Consent to Leave a Detailed Messages/Information

Dear Patient:

Dr. Lloyd requires our staff to obtain prior authorization to leave detailed voicemail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may only leave their name and a phone number in a message asking you to call them back.

By completing this consent below, you hereby authorize the staff to call and leave their name, the doctor's name, and any additional information *including test results* on a voicemail/answering machine and/or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I _____ (*print your name*) give my consent to Dr. Lloyd and/or his staff to leave voicemail/messages regarding appointments, treatments, test results, or any other necessary information at the numbers listed below.

Cell phone voicemail (_____) _____ - _____

Home voicemail (_____) _____ - _____

_____ _____/_____/_____

Patient Signature Date

I _____ (*print your name)* **DO NOT GIVE MY CONSENT TO ANY MESSAGES BEING LEFT ON A VOICEMAIL OR ANSWERING MACHINE OTHER THAN THE CALLER'S NAME AND PHONE NUMBER.**

_____ _____/_____/_____

Patient Signature Date

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PATIENT REGISTRATION FORM: MALE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Primary Care Physician Name: _____

Physician Phone Number: _____ Date of Last Physical: _____

1. What is the reason for your visit today? If it is a problem, please describe the symptoms and be specific: _____

2. Please list any medications you are currently taking and the dosage amount: _____
_____

3. Do you have any **drug allergies**? □ YES □ NO

If yes, please list the drugs you are allergic to: _____
_____

4. Do you have any thyroid problems? □ YES □NO

If yes, which type? □ Low Function □ Overactive □ Goiter □ Hashimoto

5. Are you using any form of Testosterone or Hormone Therapy? □ YES □ NO

If yes, please describe _____

Symptom Checklist

Please indicate if you have the following:

	YES	**NO**			**YES**	**NO**
Do you have erectile dysfunction?				Anxiety		
Is intercourse satisfying?				Irritability		
Do you initiate intercourse?				Mood swings		
Do you achieve orgasm?				Migraines		
Do you suffer from premature ejaculation?				Memory loss		
Is your sex drive similar as it was five (5) years ago?				Foggy thinking		
How often do you have intercourse?				Muscle loss		
Fatigue				Poor response to exercise		
Decrease in energy level				Poor recovery from exercise		

Please describe below the way in which the issues on the previous page have been dealt with:

Prostate & Testicular History

1. Age of first intercourse experience: _____
2. Are you currently sexually active? □ YES □ NO
3. Have you had any sexually transmitted diseases (STD's)? □ YES □ NO
   Please list: _____
4. Have you had a sperm count? □ YES □ NO
   What were the results of the sperm count? _____
5. Have you had the mumps? □ YES □ NO
   When did you have the mumps? _____
6. Have you ever had testicular cancer? □ YES □ NO
   If yes, when did this occur? _____
   What type of treatment did you receive? _____
7. Do you have prostate problems? □ YES □ NO
8. Do you have or have you ever had prostatitis? □ YES □ NO
9. Is your prostate enlarged? □ YES □ NO
10. Have you ever had prostate cancer? □ YES □ NO
    If yes, when did this occur? _____
    What type of treatment did you receive? _____
11. Have you ever had blood in your urine? □ YES □ NO
    If yes, when did this occur? _____
    Please describe treatment used: _____
12. Do you have bladder or kidney issues? □ YES □ NO
    If yes, please describe current treatment: _____

Medical History

1. Have you experienced weight gain in the last 1-2 years? □ YES □ NO

   If yes, please describe: _____

2. Have you lost more than 10 pounds in the last month? □ YES □ NO

   If yes, why? _____

3. Have you ever had leukemia or lymphoma? □ YES □ NO

   If yes, what type? _____

   Please describe treatment used: _____

4. Do you have a heart murmur? □ YES □ NO

5. Do you have or have you ever had kidney disease? □ YES □ NO

6. Have you ever been treated for a psychiatric disorder? □ YES □ NO

   If yes, please name the disorder: _____

7. Have you ever had rheumatic fever? □ YES □ NO

8. Do you have mitral valve prolapses? □ YES □ NO

9. Have you ever had a urinary tract infection? □ YES □ NO

10. Have you ever had hepatitis? □ YES □ NO

    If YES, which type? □ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

11. Have you ever had liver disease? □ YES □ NO

12. Have you ever had varicose veins? □ YES □NO

13. Have you ever had phlebitis? □ YES □NO

14. Have you ever had a blood transfusion? □ YES □ NO

15. Do you have a lung disease? □ YES □ NO

16. Do you have asthma, emphysema or chronic bronchitis? □ YES □ NO

Medical History (*continued*)

17. Do You have lupus, scleroderma, or collagen disease? □ YES □ NO

18. Do you have arthritis? □ YES □ NO

If yes, what type? _____

19. Have you ever had any problems with your blood? □ YES □ NO

If yes, please list the problem (such as anemia or excess blood cells): _____

_____

20. Have you ever had multiple myeloma? □ YES □ NO

Please describe treatment used: _____

21. Have you had any major accidents? □ YES □ NO

Please describe: _____

22. Please list all operations/hospitalizations (including year and reason): _____

_____

25. Have you ever had any anesthesia complications? □ YES □ NO

If yes, please describe: _____

26. Have you ever had your cholesterol checked? □ YES □ NO

If yes, what was the date it was last checked? _____

How was your cholesterol? □ Low □ Normal □ Hig

Social History

1. Do you smoke cigarettes? □ YES □ NO

Average number smoked per day: _____ How many years have you been smoking? _____

2. Do you use recreational drugs? □ YES □ NO

3. Do you drink alcohol? □ YES □ NO

If yes, what type of alcohol do you drink? _____

How many drinks per week, on average, do you drink? _____

Family History

1. Please circle YES for those that apply to YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement please list the relationship to you.

		If **YES**, who in your family history?
Alcoholism	**YES NO**	
Anemia	**YES NO**	
Arthritis	**YES NO**	
Asthma	**YES NO**	
Cancer of the breast	**YES NO**	
Cancer of the colon	**YES NO**	
Cancer of the ovaries	**YES NO**	
Cancer of the prostate	**YES NO**	
Cancer of the uterus	**YES NO**	
Cancer, other unspecified	**YES NO**	
Colon polyps	**YES NO**	
Depression	**YES NO**	
Diabetes	**YES NO**	
Glaucoma	**YES NO**	
Heart disease (CAD)	**YES NO**	
Elevated Cholesterol	**YES NO**	
Hypertension	**YES NO**	
Osteoporosis	**YES NO**	
Pulmonary embolism/DVT	**YES NO**	
Stroke	**YES NO**	
Thyroid disease	**YES NO**	

Physician Signature _____ Date _____

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