Prime Male Medical

INFORMED PATIENT CONSENT

Dear Patient,

A doctor who may perform some diagnostic tests will attend to you shortly. The first test is called *Echo Doppler* Ultrasound. It measures the blood flow through the penis. Your doctor will first locate the cavernosal artery in the penis and measure "passive" blood flow (when you are not sexually excited). The doctor then usually applies a dose of medication to the spongy tissue of the penis using an auto-applicator. This application is painless. The medication contains a combination of commonly used vasodilators including Papaverine, Phentolamine, Atropine and Prostaglandin E1. It will dilate the capillaries so that the "active" blood flow (as when you are sexually excited) through the penis can be measured. A partial or full erection lasting 40-60 minutes usually results from this application.

Rarely, this application may produce a full erection lasting longer than two hours. Such prolonged erection is unusual and only occurs in those who are overly sensitive to the combination used. Should there be a possibility of this occurring; you will be advised on what procedures should be followed. Other rare effects of this procedure include lightheadedness mostly due to nervousness.

I, ______________________________________, fully understand the nature of the above tests and the possible side effects. I consent to a medical consultation fee of ~~$699.00~~ $99.00* upon completion of the visit, and understand that the charges paid for any other medication which I may elect to purchase are final. I consent to treatment by my treating doctor should I experience any inopportune symptoms. I also understand that these services are considered elective treatment and are not covered by Medicare, and that any medications ordered by me are by law non-refundable.

I hereby authorize Prime Male Medical to maintain the medical records and medical charts for medical services provided to me, and I have read and understand Prime Male Medical Center HIPAA Statement and Notice of Privacy Practices.

I hereby warrant that my overseeing physician(s) have deemed me healthy enough for sexual activity.

Signed this _______day of __________, 2017

Patient's Signature: ____

Doctors Signature: ____

Physician Assistant Signature:____________________________________

*** I understand that Prime Male Medical guarantees that in the event I fail to achieve an erection during the initial office visit, there will be no charge for the office visit. However, in the event that I complete the office visit having achieved the erection, the cost of the office visit, the medications, and/or other services or products, shall be non-refundable and the no cost GUARANTEE shall terminate at the time the office visit had ended.**

Prime Male Medical

Patient Profile Sheet

Name: ______________________________ Date: _________________

Address: ____________________________ City: _________________

State: ______ Zip: __________ Phone #: ________________

Work #: ________________________ Cell #: __________________

Age: _______ DOB: _________ Occupation: ____________

Employer: ____

SSN: _________________ Driver's License: _______________

Email address: ____

*May we contact you via email? YES NO

**Would you like to be notified of our promotions, discounts and specials via email? YES NO

Medical Insurance Data

Insurance Company

____

HMO________

PPO_________

Employer

____

Social History:

Do You Smoke? __Yes__No How Many Packs Per Day? ______________

Marital Status: __Single__Married__Divorced__Separated__Widowed

Physical Activity: __Inactive__Light__Moderate__Heavy

How did you hear about Prime Male Medical?

- **Newspaper**: San Francisco Chronicle Oakland Tribune The Examiner
- **Other Publication**: Which one?_________________________________
- **Dr. Referral** - Dr. Name? _________________________________

Radio: KSAN 107.7 FM The Bone KCBS 740 AM KCBS 106.6 FM KNBR 680 AM KTCT 1050 AM KFRC 1550 AM KFOG 97.7 FM 104.5 FM KGO 810 AM KSFO 560 AM KNEW 910 AM KKSF 103.7 KTRB 860 AM XTRA Sports KFOX 98.5 FM 102.1 FM ESPN deportes 860 AM

- **Friend**: Whom can we thank? ____
- **TV:** KOFY / KRON / ESTRELLA • **Other:** ____

Would You Like Information Regarding:

_____Weight Loss
_____Cosmetic Surgery
_____Other

____ Natural Hormone Replacement
____ Nutritional Counseling

Patient Signature: ___________________________ Date: _________________

Medical Questionnaire

(Please circle yes or no)

Medical History

Diabetes	Yes	No	High Cholesterol	Yes	No
High Blood Pressure	Yes	No	Coronary Heart Disease	Yes	No
Heart Attack	Yes	No	Blocked Artery	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Multiple Sclerosis	Yes	No	Parkinson's disease	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Bowel Problems	Yes	No	Prostate Disease	Yes	No
Prostate Cancer	Yes	No	Peyronie's Disease	Yes	No
Sexually Transmitted	Yes	No	HIV Infection/ Aids	Yes	No
Blood Transfusion	Yes	No	Major Depression	Yes	No
Tuberculosis	Yes	No	Bleeding Disorder	Yes	No

Other____

Surgery

Heart	Yes	No	Blocked Artery	Yes	No
Prostate	Yes	No	Penis	Yes	No
Bowel	Yes	No	Bladder	Yes	No
Hernia	Yes	No	Head	Yes	No
Vasectomy	Yes	No	Spine	Yes	No

Other____

Previous Urology Problems

Kidneys	Yes	No	Penis	Yes	No
Bladder	Yes	No	Testicles	Yes	No
Prostate	Yes	No	Urine	Yes	No

Injuries

Head	Yes	No	Back	Yes	No
Pelvis	Yes	No	Penis	Yes	No

Other____

Family History

Diabetes	Yes	No	Premature Heart Attack	Yes	No
Cancer of the Prostate	Yes	No	High Blood Pressure	Yes	No

Other Significant Ailments____

Allergies

Have you ever had an allergic reaction to any medications? Yes No

If yes, please provide details:

Ethnicity

American Indian or Alaska Native _______ Asian _______ Black or African American _______
Native Hawaiian or Other Pacific Islander _______ White _______ Hispanic _______

Questionnaire (continued)
Main Complaints Today:

			If yes, for what time period
Difficulties in getting an erection	yes	no	______________________________
Difficulties in maintaining an erection	yes	no	______________________________
Early Ejaculation	yes	no	______________________________
Unable to ejaculate	yes	no	______________________________
Painful ejaculation	yes	no	______________________________

Please describe your main sexual complaints:

____

Please provide your current physicians:

	Name	Phone	Specialty	Last Visit
Family Physician	______________________	__________	________________	________________
Specialist	______________________	__________	________________	________________
Specialist	______________________	__________	________________	________________
Specialist	______________________	__________	________________	________________
Other Physician	______________________	__________	________________	________________
Other Physician	______________________	__________	________________	________________

May we contact your Physician(s) about your success at Prime Male Medical so that other patients may benefit? ___Y____N

Current medications (pills, injections, laxatives, sedatives, vitamins, aspirin, Plavix, blood thinners, or others)

____

____

____

Have you used any medications for Erectile Dysfunction?

	Never Used	When Started	When Stopped	Results
Viagra	____________	____________	____________	____________
Cialis	____________	____________	____________	____________
Levitra	____________	____________	____________	____________
Injections	____________	____________	____________	____________
Muse	____________	____________	____________	____________

Other____

The following to be completed by Physician or staff member

Reviewed by: ________________________________