Comprehensive Healthcare Inc.

797 North State Road 434 Altamonte Springs Florida 3271

Men's Health

Patient Information

First Name: _____ MI:_____Last Name:_____

Email address: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female

Marital Status:❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ___

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Emergency Contact: _____ Relation: _____ Phone #: _____

How did you hear about our practice? _____

GAINSWave®

Patient Name:_____ Patient DOB:_____

Email:_____ Phone Number:_____

Procedure: **GAINSWave®** ☐ **GAINSWave® + Gaines Enhancement®** ☐

Primary Goal**: Erectile Performance** ☐ **ED** ☐ **Peyronie's** ☐

Medical History**: DM** ☐ **HTN** ☐ **CVD** ☐

Current Med Use**: Beta-Blockers SSRIs PDE5i [Cialis, Viagra]**

Prior use of PDE5i: yes PDE5i Response**: None / Poor / Good**

○ ○ ◉

The Erectile Hardness Score [*choose one*]

1. Penis is larger, but not hard ◉
2. Penis is hard, but not hard enough for penetration ○
3. Penis is hard enough for penetration, but not completely hard ○
4. Penis is completely hard and fully rigid ○

SHIM

1. How would you rate your confidence that you can get and keep an erection? 1
1=very low 2=low 3=moderate 4=high 5=very high

2. When you have erections with sexual stimulation, how often are your erections hard enough for penetration? 1
1=never 2=a few times 3=sometimes 4=most times 5=always

3. During sexual intercourse, how ften were you able to maintain your erection after you had penetrated your partner? 1
1=never 2=a few times 3=sometimes 4=most times 5=always

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse? 1
1=extremely difficult 2=very difficult 3=difficult 4=slightly difficult 5=not difficult

5. When you attempt sexual intercourse, how often is it satisfactory for you? 1
1=never 2=a few times 3=sometimes 4=most times 5=always

For office use only:

RESULTS

Follow up: DATE:___/

____/____ Erectile Hardness Score _____

SHIM Total Score____

1-7 Severe ED 8-11 Moderate ED 12-16 Mild moderate ED 17-21 Mild ED 22-25 No ED

Revd. 10/26/17

Patient Name: _____ Date:_____

Age:_____ DOB:_____ Height:_____ Weight:_____

What area(s) of improvement are you interested in?_____

_____

List any ED medications you are currently taking or have used in the past: _____

Did they work?:_____

List any conditions/medical history you currently have or have had in the past:

List any known allergies: _____

When was the last time you saw a doctor for a physical exam? _____

List all medications and supplements you are currently taking:

Medications	Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:_____ Date:_____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Comprehensive Health Care INC. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Witness (Office Staff) Date