MEN'S ENERGY, LONGEVITY & PERFORMANCE

NEW PATIENT INTAKE PACKET

Please complete this packet before your consultation. Your answers determine which laboratory tests are ordered for you. Intake information only — not a prescription, consent, or complete medical record.

1. ABOUT THIS PROGRAM

The Men's Energy, Longevity & Performance Program is a physician-directed evaluation of the medical factors behind low energy, reduced strength, weight gain, poor recovery and general decline in vitality. Looking better matters as much as feeling better, so the program also covers the nonsurgical appearance treatments available in our office.

Care begins with a comprehensive history and an individualized laboratory panel, followed by a consultation, a written treatment plan and scheduled laboratory monitoring.

The program is not intended to replace primary care or specialty care. Significant abnormalities identified during screening may require evaluation by your primary-care physician or an appropriate specialist.

HOW THE PROGRAM WORKS

1. You complete and return this intake packet.
2. Your physician reviews it and sends an individualized lab order.
3. You complete your blood draw — morning fasting draw preferred.
4. Labs and questionnaire are reviewed before you are seen.
5. Comprehensive consultation and review of your results.
6. You receive a written plan and a repeat-laboratory interval.

WHAT WE EVALUATE AND TREAT

Hormone & Vitality Optimization. Evaluation for testosterone deficiency; injectable or topical testosterone therapy when medically appropriate; dose adjustment and laboratory monitoring.

Medical Weight Loss. Semaglutide or tirzepatide when appropriate, with nutrition, protein and exercise recommendations and metabolic monitoring.

Energy & Nutrient Optimization. Vitamin D, B12, iron and ferritin, and magnesium evaluation and correction; injectable B12 when appropriate.

Performance & Recovery. Resistance training, aerobic conditioning, protein intake, creatine, hydration, sleep and recovery strategies.

Appearance & Skin. Nonsurgical options to look as good as you feel — medical-grade skin care, laser and energy-based treatments, neuromodulators such as Botox, and dermal fillers, provided by our aesthetic team.

NAD+ Therapy. Injectable and/or IV NAD+ as an adjunctive energy and recovery therapy when appropriate.

Advanced Performance & Recovery Therapies. Selected compounded therapies, including peptide-based recovery and performance therapies, considered individually when available and medically appropriate.

2. SERVICES YOU MAY BE INTERESTED IN

Check anything you would like to discuss. Checking a box does not commit you to treatment, and your physician may recommend a different pathway.

- ☐ Low energy / fatigue evaluation
- ☐ Testosterone evaluation
- ☐ Testosterone therapy — injectable
- ☐ Testosterone therapy — topical
- ☐ Medical weight loss (GLP-1)
- ☐ Nutrition & protein guidance
- ☐ Vitamin / nutrient deficiency
- ☐ Injectable B12
- ☐ NAD+ therapy
- ☐ Sleep & recovery optimization
- ☐ Advanced recovery therapies
- ☐ Strength or muscle loss
- ☐ General longevity / healthy aging
- ☐ Medical-grade skin care
- ☐ Laser or energy-based skin treatment
- ☐ Botox or other neuromodulator
- ☐ Dermal fillers
- ☐ Not sure / provider recommendation

3. YOUR GOALS

- ☐ More energy
- ☐ Lose weight
- ☐ Build strength / muscle
- ☐ Better recovery
- ☐ Better sleep
- ☐ Improved mood / motivation
- ☐ Libido / sexual health
- ☐ Athletic performance
- ☐ Look as good as I feel
- ☐ Refreshed, less tired appearance
- ☐ Better skin quality
- ☐ Reduce lines or wrinkles

My top three goals, in my own words

_____

_____

Target weight, if applicable

_____

By when

_____

PATIENT INFORMATION & HEALTH HISTORY

4. PATIENT BASICS

Name | Date of birth | Age | Today's date

Phone | Email | Primary-care physician and practice

Height | Current weight | Weight one year ago | Highest adult weight | Blood pressure, if known

Date of last physical exam | Date of last blood work | Where your last blood work was drawn

5. MEDICAL HISTORY — CHECK ANYTHING YOU HAVE NOW OR HAVE HAD

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes / prediabetes
- ☐ Heart disease
- ☐ Irregular heartbeat
- ☐ Stroke / TIA
- ☐ Blood clot / DVT / PE
- ☐ Clotting or bleeding disorder
- ☐ High red blood cell count
- ☐ Sleep apnea
- ☐ Asthma / COPD
- ☐ Kidney disease
- ☐ Liver disease / fatty liver
- ☐ Thyroid disease
- ☐ Pituitary disorder
- ☐ Low testosterone
- ☐ Infertility / low sperm count
- ☐ Prostate enlargement / BPH
- ☐ Elevated or abnormal PSA
- ☐ Prostate cancer
- ☐ Any other cancer
- ☐ Pancreatitis
- ☐ Gallbladder disease
- ☐ Reflux / gastroparesis
- ☐ Bowel obstruction
- ☐ Medullary thyroid cancer / MEN2
- ☐ Eating disorder
- ☐ Depression / anxiety
- ☐ Migraines
- ☐ Autoimmune disease
- ☐ Anemia
- ☐ Chronic pain or injury

Other conditions, or details on anything checked above

6. SURGICAL HISTORY & FAMILY HISTORY

Surgeries and hospitalizations, with approximate year

☐ Surgery or procedure scheduled:

Family history — check any that apply to a parent or sibling

- ☐ Heart disease
- ☐ Diabetes
- ☐ Prostate cancer
- ☐ Thyroid disease
- ☐ Blood clots
- ☐ Stroke
- ☐ Medullary thyroid cancer / MEN2
- ☐ Other cancer

7. YOUR ENERGY & PERFORMANCE, IN YOUR OWN WORDS

How have your energy, strength, focus or recovery changed, and when did you first notice it?

What have you already tried to address it, and what happened?

MEDICATIONS, SUPPLEMENTS & PRIOR THERAPIES

8. CURRENT PRESCRIPTION MEDICATIONS

MEDICATION	DOSE	HOW OFTEN	WHAT IT IS FOR

☐ I take no prescription medications.

9. SUPPLEMENTS, VITAMINS & OVER-THE-COUNTER PRODUCTS

Include protein powders, pre-workout, creatine, testosterone boosters, herbal products and anything purchased online.

☐ Multivitamin ☐ Vitamin D ☐ Vitamin B12 ☐ Iron

☐ Magnesium ☐ Zinc ☐ Omega-3 / fish oil ☐ Creatine

☐ Protein powder ☐ Pre-workout / stimulant ☐ Testosterone booster ☐ DHEA

☐ NAD+ / NMN / NR ☐ Herbal or botanical products ☐ Weight-loss supplements ☐ None

SUPPLEMENT / PRODUCT	DOSE	HOW OFTEN	HOW LONG

10. PRIOR OR CURRENT HORMONE, WEIGHT-LOSS & PERFORMANCE THERAPIES

☐ Testosterone — injectable ☐ Testosterone — gel or cream ☐ Testosterone — pellets

☐ hCG / clomiphene / enclomiphene ☐ Anastrozole / aromatase inhibitor ☐ Anabolic steroids / SARMs

☐ Semaglutide / Ozempic / Wegovy ☐ Tirzepatide / Mounjaro / Zepbound ☐ Other weight-loss medication

☐ Peptides — BPC-157, TB-500, other ☐ NAD+ injection or IV ☐ Vitamin injections or IV therapy

Details — what, when, dose, and who prescribed it

Side effects, or reason you stopped

11. ALLERGIES & REACTIONS

Medication allergies and the reaction

Other allergies — latex, adhesives, foods, preservatives

SYMPTOM REVIEW & LIFESTYLE

12. SYMPTOM REVIEW — CIRCLE 0 (NONE) TO 5 (SEVERE) FOR THE PAST MONTH

Low energy or fatigue	0	1	2	3	4	5	Poor recovery after exercise	0	1	2	3	4	5
Afternoon energy crash	0	1	2	3	4	5	Reduced exercise performance	0	1	2	3	4	5
Reduced motivation or drive	0	1	2	3	4	5	Joint or muscle aches	0	1	2	3	4	5
Low mood or irritability	0	1	2	3	4	5	Poor sleep quality	0	1	2	3	4	5
Difficulty concentrating	0	1	2	3	4	5	Snoring or witnessed apnea	0	1	2	3	4	5
Loss of strength	0	1	2	3	4	5	Reduced libido	0	1	2	3	4	5
Loss of muscle mass	0	1	2	3	4	5	Hot flashes or night sweats	0	1	2	3	4	5
Increased body fat, especially midsection	0	1	2	3	4	5	Frequent illness or slow healing	0	1	2	3	4	5
Weight gain despite unchanged diet	0	1	2	3	4	5	Swelling in legs or ankles	0	1	2	3	4	5
Increased appetite or cravings	0	1	2	3	4	5	Digestive symptoms	0	1	2	3	4	5
Headaches	0	1	2	3	4	5							

13. LIFESTYLE

TRAINING

Resistance training, days per week _____

Cardio, days per week _____

Typical session length _____

Sports or activities _____

SLEEP & STRESS

Average hours of sleep _____

- ☐ Trouble falling asleep
- ☐ Wake at night
- ☐ CPAP use
- ☐ Shift work

Stress level, 0 to 10 _____

Recovery days per week _____

NUTRITION & SUBSTANCES

Meals per day _____ Protein, grams per day _____

Alcohol, drinks per week _____

Caffeine, servings per day _____

- ☐ Tobacco / nicotine
- ☐ Cannabis
- ☐ Meal delivery / plan
- ☐ Tracking intake

14. FERTILITY & TESTOSTERONE-SPECIFIC QUESTIONS

Testosterone therapy can reduce sperm production and fertility. These answers affect which treatment is appropriate for you.

- ☐ I may want to father children in the future
- ☐ I am currently trying to conceive
- ☐ I am subject to occupational or athletic drug testing
- ☐ I have completed my family / had a vasectomy
- ☐ I have had a fertility evaluation

Anything else you would like your physician to know before your visit

SAFETY SCREENING & ACKNOWLEDGMENT

Screening only — not a full medical history, consent, or prescription. Any YES response will be reviewed before treatment is prescribed or administered.

15. PRIORITY SAFETY SCREENING — ANSWER YES OR NO

YES	NO	QUESTION	DETAILS / NOTES
		1. Any history of prostate cancer, elevated PSA, or an abnormal prostate exam?	
		2. Urinary symptoms — weak stream, frequency, night-time urination, retention?	
		3. Any history of breast cancer or male breast enlargement?	
		4. Blood clot, DVT, PE, stroke, TIA, heart attack, or known clotting disorder?	
		5. High red blood cell count, high hematocrit, or a history of blood donation for this?	
		6. Untreated or suspected sleep apnea?	
		7. Congestive heart failure, uncontrolled blood pressure, or recent cardiac event?	
		8. Desire to father children now or in the future?	
		9. Personal or family history of medullary thyroid cancer or MEN2?	
		10. History of pancreatitis, gallstones, or gallbladder disease?	
		11. Severe reflux, gastroparesis, bowel obstruction, or chronic nausea and vomiting?	
		12. Diabetes, low blood sugar episodes, or use of insulin or sulfonylurea medication?	
		13. Kidney disease, liver disease, or dehydration requiring medical care?	
		14. Eating disorder history, severe food restriction, or concerning appetite loss?	
		15. Current cancer treatment, active infection, or a non-healing wound?	
		16. Blood thinner use, bleeding disorder, or easy and severe bruising?	
		17. Serious allergic reaction to an injection, peptide, GLP-1 medication, or hormone?	
		18. Surgery, anesthesia, endoscopy, or another procedure coming up?	

16. PATIENT ACKNOWLEDGMENT

- ☐ The information I have provided is accurate and complete to the best of my knowledge.
- ☐ I understand this program is not a substitute for primary care or specialty care.
- ☐ I understand treatment requires provider review, laboratory evaluation and separate written consent.
- ☐ I understand some therapies may be compounded and prescribed off-label, and that compounded medications are not FDA-approved or reviewed by the FDA for safety, effectiveness or quality before marketing.
- ☐ I will report side effects, medication changes, new diagnoses and upcoming procedures, and will not change my dose or share medication.

Patient signature _____ Printed name _____ Date _____

FOR OFFICE USE ONLY

Reviewed by _____ Date reviewed _____ Lab order sent _____ Additional labs indicated _____