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New Patient Forms

PLEASE PRINT AND FILL IN ALL THE BLANKS

Today's Date: _____

PATIENT NAME _____DATE OF BIRTH _____

ADDRESS_____ SEX _____

CITY_____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

EMPLOYER/OCCUPATION_____

WORK ADDRESS _____

CITY_____ STATE _____ ZIP _____

IN CASE OF EMERGENCY CONTACT: _____

CONTACT PHONE NUMBER: _____

RELATIONSHIP TO YOU: _____

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Health History

HAVE YOU HAD OR DO YOU CURRENTLY… (please check all that apply)

	High blood pressure		Low sex drive
	Chest pain/angina		Blood disorder such as anemia
	Heart attack(s)		Bruise easily
	Irregular heart beat		Gallbladder trouble
	Cardiac pacemaker		Fainting spells
	Are you on dialysis?		Thyroid trouble
	Stomach ulcers		Diabetes
	History of breast cancer		Low blood sugar
	History of uterine cancer		Swollen ankles, arthritis, or joint disease
	History of ovarian cancer		Sleep apnea
	History of prostate cancer		Insomnia or poor sleep quality

ARE YOU CURRENTLY TAKING… (please check all that apply)

	Blood thinners		Blood pressure meds
	Sleep-inducing medications		Aspirin
	Cortisone		Ibuprofen or Tylenol
	Medications for acid reflux or GERD		Antihistamines/decongestants
	Prescription appetite suppressants (Adipex, phentermine, etc.)		Antidepressants or anxiety medications
	Thyroid meds		Muscle relaxants or tranquilizers
	Antibiotics		Insulin or diabetic meds

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Health History

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO…

(please check all that apply)

	Local anesthetics
	Penicillin
	Other Antibiotics
	Aspirin
	Codeine or other narcotics
	Any other drug allergies?
	Latex

WOMEN…

	Could you possibly be pregnant?
	Are you currently on birth control?
	Date of your last menstrual period: _____
	Date of your last pap smear: _____
	Date of your last mammogram: _____

MEN…

	Date of your last prostate exam: _____
	Date of your last PSA test: _____

CURRENT HEIGHT _____ **CURRENT WEIGHT** _____

Do you consider yourself in good health? _____YES _____ NO

Any change in your health in the past year? _____ YES _____ NO

Are you under the care of a physician? _____ YES _____ NO

Pulse_____ **BP** _____ **EKG** _____**Yes** _____**No**

Have you ever been hospitalized? If so, please list dates and reasons for your Hospitalization:

_____

_____

_____

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I certify that I have read and understand the questions in these forms; I acknowledge that I will have the opportunity to discuss my health history with my doctor. I will not hold my doctor or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of these forms.

SIGNATURE OF PATIENT _____

Consent to antibody testing: In the event of an accidental exposure to blood or other bodily fluids through needle stick, cut, mucous membrane contact, or the like, the undersigned consents to appropriate tests for the presence of Hepatitis B & C and HIV, which is the virus believed to cause AIDS. The patient will be informed of any positive results, and all such results will be treated as confidential by *Chimera Medical Services.* There is no charge to the patient.

SIGNATURE OF PATIENT _____

Current Meds/Supplements	Strength	Dose/Comments

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CONSENT FOR TREATMENT

This consent for treatment is made and entered into this _____(date) day of _____ (month), _____ (year), by and between Chimera Medical, Ken Taylor, M.D. ("Physician") and _____ ("Patient").

I hereby state that I have honestly and without exaggeration or omission, completed the attached "New Patient Forms." I also state that I have disclosed any and all information that might reasonably be considered relevant to decisions made by Physician regarding my care. I have disclosed all past illnesses, particularly those involving any form of cancer. I also state that I have disclosed all medications that I am taking at the present time and will inform Physician of any medications that may be prescribed now and in the future by other physicians. I also state that I have disclosed the past and present use of any substances including prescribed or nonprescription drugs, alcohol, steroids, vitamins, and dietary supplements. I hereby hold harmless and waive any claim or defense against Physician for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to Physician. I waive any claim or defense against Physician for any harm or injury I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by Physician. I agree to immediately cease any medical treatment prescribed by Physician in the event of any adverse response or side effect arising from prescribed treatment and to provide immediately notice of such adverse response or side effect to Physician via phone or office visit. I agree to comply with the prescribed instructions for use of all medications prescribed by Physician. I agree all medications are for my personal use and are not to be used by anyone other than myself.

I understand that the practice of medicine is not an exact science and that all diagnosis and treatment may involve risks of injury, including but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of the diagnostic testing analysis of test results, examination of medical history, or treatment by Physician.

I acknowledge and accept that Physician may not physically see me and will use lab testing, "New Patient Forms," a physical done by my primary care physician and provided by me to Physician, and telephonic conversations as the primary basis for diagnosis and treatment of any condition(s) I may have.

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I have been informed that all patients are recommended to have a full body scan prior to and periodically while on Peptides, IGF-1 and BHRT therapies for the identification of potential issues such as cancer or other issues that may occur on these therapies. I have read and understand all of the above and have been informed of the potential side effects and risks associated with the use of Peptides, IGF-1 and BHRT therapies. I fully understand what I am signing and hereby request and consent to anti-aging/ weight loss treatment using prescription injections of Peptides, IGF-1 or BHRT therapies.

I am or have been made aware to my satisfaction of the nature, risk, possible alternative methods of treatment, possible consequences, and possible complications involved in a course or treatment utilizing prescriptions for weight loss or hormone replacement therapy (BHRT). I am also aware that some studies exist that show a possible connection between hormone therapy and cancer. I am also aware that in the event that I develop some form of cancer, hormones that I am taking may make the cancer worse. Additionally, I am aware that use of hormones may, in some cases, cause a decrease in the body's natural ability to produce those hormones. I have read and understand the forgoing CONSENT FOR TREATMENT and have signed the same as by voluntary act and deed.

_____ _____

PLEASE PRINT NAME **DATE**

_____ _____

PLEASE SIGN NAME **DATE**