



30 Central Park South, New York, NY 10019
(212) 888-7074 fax (212) 888-7828
Ronald V. Livesey, MD Joseph M. Raffaele, MD

NOTE: Please return this completed form to us within 3 days.

Medical Questionnaire

Name: _____ Date: _____

Billing Address: _____

City, State, ZIP: _____ Birth date: _____

Phone (Home): _____ (Work): _____

(Fax): _____ Social Security # : _____

Phone (Cell): _____ E-mail: _____
(Strictly for treatment-related communication)

Shipping Address: _____
(if different)

Employer: _____ Occupation: _____

Insurance (Lab tests only): _____
(Insurance Name and Plan) (Patient relationship to insured)

(Policy ID #) (Group/plan #) (Employer/group name) (Name of insured if not self)

(Insurance company address and phone number)

In case of emergency contact (Name): _____

Phone: _____ Relationship: _____

Primary Care Physician (Name, address, and phone): _____

How did you hear about us? _____

Reason for appointment: _____



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List your current medical problems (e.g., diabetes, high blood pressure, chronic fatigue, arthritis) in chronological order, latest to oldest.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____



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Medical History: List all past illnesses and the dates of any associated hospitalizations.
For example, pneumonia, hospitalized 2/84.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

List all surgeries with dates.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____



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Please list all prescription medications (doses and frequencies) you currently take.

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

Please list all non-prescription medications, vitamins, and supplements you currently take.

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

List any allergies to medications or supplements.

1. _____
2. _____
3. _____



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Are any of the following diseases in your immediate family? If yes, please note the **age** at which the family member **contracted the disease**. (i.e. Father: age 42)

- 1. Cardiovascular disease? _____
- 2. Diabetes? _____
- 3. Colon cancer? _____
- 4. Breast cancer? _____
- 5. Prostate cancer? _____
- 6. Skin cancer? _____
- 7. Please list any other diseases that run in your family.

What has been your occupation over the past 10 years? _____

Marital status: Married Divorced Separated Widow Single
of Children _____

Have you ever smoked cigarettes, cigars, or pipes? _____
How many years? _____ Have you quit? _____ If so, when? _____

Have you ever used any recreational drugs? _____
How many years? _____

How much alcohol do you drink? One drink equals 4 oz wine, 12 oz beer, 1 oz liquor.
Less than two drinks a week? _____
2 to 5 drinks a week? _____
6 to 14 drinks a week? _____
14 or more drinks a week? _____



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The following long and somewhat tedious list is designed to reveal symptoms of aging and early manifestations of disease you may not have recognized yet. Please **check off** the boxes that apply or have applied to you, or answer the questions appropriately.

General Symptoms

- More tired than you would like to be on a daily basis
- Been depressed recently
- Lost interest in life recently
- Anxious on a regular basis
- Sleep 7 or more hours a night
- Sleep less than 7 hours a night
- Loss of ambition
- Loss of determination
- Loss of Optimism

Cardiopulmonary

- Chest pain at rest
- Chest pain with exertion
- Heart has beat irregularly
- Short breath with minimal exertion
- Shortness of breath when you lie flat on your back
- Ankles swell significantly if you stand or walk for a long time
- Calves burn if you walk more than a short distance
- Appears as if a shade were being pulled over either eye for a short time
- Wheezing

Gastrointestinal

- Frequent heartburn
- Take antacids frequently
- Burning in your stomach if you haven't eaten for a while
- Vomited up blood or coffee ground appearing material
- Sense of being full before eating much of a meal
- Milk products cause bloating of your stomach, belching, or the passing of gas
- Take lactose intolerance aids regularly
- Frequently constipated
- Loose stools regularly
- Blood in your stools
- Hemorrhoids
- Abdominal cramping regularly with eating
- Common for you to feel weak, or break into a sweat a few hours after eating
- Trouble swallowing



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Neurological

- Tingling of your hands or feet
- Intermittent weakness of any of your extremities
- Frequent headaches
- Get dizzy if you turn your head quickly
- Sometimes have difficulty talking distinctly
- Tremor or shaking of your hands
- Ability to remember things worsened lately

Musculoskeletal

- Frequent aching of your joints
- Frequent swelling of your joints
- Frequent back pain
- Frequent neck pain
- Decrease in your muscle tone/size in the past year
- Aching in your feet or heels when you take you first steps in the morning

Endocrine

- Unduly sensitive to heat or cold
- Weight loss of 10 lbs. or more in the past 6 months
- Weight gain of 10 lbs. or more in the past 6 months
- Weight stayed constant in the past 5 years
- Increase in fat around your waist in the past 5 years

Skin

- Have dry skin regularly
- Have dry skin in the winter only
- Have pimples or acne frequently
- Skin has been wrinkling more in the past year
- Bruise easily
- Get rashes regularly
- Skin itches regularly
- Hair dry
- Hair oily
- Loosing your hair more rapidly lately



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Men only

Do you have a decrease in libido (sex drive)? _____

Do you have a lack of energy? _____

Do you have a decrease in strength and /or endurance? _____

Have you lost height? _____

Have you noticed a decreased "enjoyment of life"? _____

Are you sad and /or grumpy? _____

Are your erections less strong? _____

Have you noted a recent deterioration in your ability to play sports? _____

Are you falling asleep after dinner? _____

Has there been a recent deterioration in your work performance? _____

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? _____

Over the past month, how often have you had to urinate again less than two hours after you finished urinating? _____

Over the past month, how often have you found you stopped and started again several times when you urinated? _____

Over the past month, how often have you found it difficult to postpone urination? _____

Over the past month, how often have you had a weak urinary stream? _____

Over the past month, how often have you had to push or strain to begin urination? _____

Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? _____



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Women only

When was your last period? Date: _____
When was the period before the last one? Date: _____
At what age did you start menstruating? _____
How many days is it between periods? _____
How many days of flow do you have during your period? _____
How many of these are heavy flow? _____
Are your cycles regular? _____
Do you suffer from PMS? _____
Do you get breast tenderness at any time during your cycle? When? _____
Do you feel bloated during your cycle? When? _____
Do you get headaches at a particular time during your cycle? _____
Do you get more irritable or emotional before your period? _____
How many periods have you missed in the last year? _____
Do you have hot flushes? _____
Do you have vaginal dryness? _____
Is sexual intercourse painful frequently? _____
Do you have frequent yeast infections? _____
Do you have frequent urinary tract (bladder) infections? _____
On a scale of 1 to 10 (10 highest), how would you rate your sex drive? _____
Has your sex drive changed significantly since you were younger? _____
Has the quality, intensity, or frequency of your orgasms changed? _____
How many times have you been pregnant? _____
How many pregnancies resulted in a birth? _____
How did the other pregnancies end? _____
Do you wear a bra 24 hours per day? _____



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Recent Diagnostic Test Results

Most recent cholesterol _____ HDL _____ LDL _____ Triglycerides _____
Most recent PSA _____ Date _____
Most recent mammogram: Normal Abnormal Date _____
Most recent PAP smear: Normal Abnormal Date _____

Have you ever had a Sigmoidoscopy? Yes No
Normal Abnormal Date _____

Have you ever had a colonoscopy? Yes No
Normal Abnormal Date _____

Have you ever had a stress test? Yes No
If yes, when, and what was the result? _____

Have you had an electron beam CT (Imatron scan)? Yes No
If yes, when, and what was the result (if you have copy please send it)? _____

Have you had Bone Mineral Density scan? Yes No
If yes, when, and what was the result? _____

Exercise Assessment

Do you walk each day? Less than 20 min. 20 to 40 min. more than 40 min

Do you lift weights regularly? Yes No If yes, what is your routine?

Do you do cardio training? Yes No If yes, how much and how often?

Do you participate in any other regular athletic activity? If yes, please describe it.

24 hr. diet recall: list all you ate in the last 3 meals, including intervening snacks/beverages.

Breakfast: **Snack:**

Lunch: **Snack:**

Dinner: **Snack:**



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POLICIES AND PROCEDURES (Rev. 6/20/08)

1. **Shipping**
 - a. FedEx imposes a \$1.50 surcharge on shipments requiring a signature and a \$2.00 surcharge on shipments to residences. **If you do not require a signature or if you wish to change your address, please let us know.**
 - b. Patients are responsible to accept deliveries or make arrangements to have deliveries left without a signature.
 - c. PhysioAge is not responsible for loss due to delays beyond our control (i.e.; adverse weather conditions, unsuccessful delivery attempts, etc.)
 - d. FedEx is not responsible for loss due to delays beyond their control in the delivery of perishable refrigerated medications.
2. **Holiday Schedule**
 - a. **In general, any shipments scheduled to ship on a holiday will go out on the next business day and will arrive one day later than usual.** During Thanksgiving week, all shipments will be scheduled to arrive by Wednesday.
 - b. The pharmacy will not operate on the following days:

Thanksgiving Day	President's Day
Christmas Day	Memorial Day
New Year's Day	Independence Day
	Labor Day
 - c. In addition, PhysioAge Medical Group will not operate on the following days:

Thanksgiving Friday	Columbus Day
Martin Luther King Day	
3. **Appointment Policy**
 - a. **Appointments must be confirmed at least 2 business days in advance in order to guarantee the time slot.**
 - b. **Late cancellations (less than 2 business days' notice) will incur a penalty equal to 50% of the office visit fee.**
4. **Lab Testing**
 - a. **Patients receiving medications are required to provide periodic lab test results. Failure to comply with this requirement may result in a suspension of treatment.**
 - b. **Except for appointments involving an in-house blood draw, patients are required to provide specimens for testing at least 21 days before their scheduled appointment.**
5. **Prescriptions**
 - a. **Unless otherwise arranged, all prescriptions will automatically refill.**
 - b. Prescription requests submitted before 5PM EST will be shipped on the next business day. **No same-day orders will be permitted.**
 - c. Requests can be made by phone (877-PHYSIO-AGE), e-mail (Rx@PhysioAge.com) or fax (212-888-7828).
 - d. If your credit card is declined, your prescriptions will not be filled. The pharmacy will attempt to contact you by phone. If you are not available or if you do not return the call promptly, your order may be delayed. You may eliminate this possibility by providing a deposit equal to the value of one month of medications.
 - e. Prescription items are not returnable. Please check your order when it arrives and report any discrepancies within 48 hours.
6. **Program Maintenance Fee: HRT \$75 – HCG \$100 – HGH \$125**
 - a. This fee covers the cost of all follow-up consultations, e-mails, telephone calls, physical exams, analysis and review of lab tests, management of your lab follow-up requirements and treatment program, PhysioAge Diagnostic Testing (arterial compliance, body composition, lung health, and skin elasticity), and all the overhead costs of running a full-time age management practice.
 - b. This fee applies to every 28-day period as long as your physician is responsible for monitoring blood levels, managing your treatment program and treating symptoms. It does not correlate to office visits or shipments, but it is billed with your regular shipments for simplicity.
 - c. **This fee will continue to be billed unless you discontinue treatment.**



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NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996, Privacy Rule

- We (PhysioAge Medical Group) must make all reasonable efforts to safeguard your protected health information;
- We must use and disclose your protected health information for the purposes of treatment, payment, and other healthcare operations only;
- We must obtain your specific authorization to use or disclose your protected health information for purposes other than treatment, payment, or other healthcare operations;
- We must make information available to healthcare agencies on demand;
- We must make information available to law enforcement agencies on demand.

You have the right:

- To receive our Notice of Privacy Practices.
- To revoke an authorization which allows us to use or disclose your protected health information for purposes other than treatment, payment, or other healthcare operations, at any time.
- To inspect your protected health information.
- To receive a copy of your protected health information.
- To request an amendment of your protected health information.
- To complain about any breaches of privacy.

“I have received and read the Notice of Privacy Practices issued by PhysioAge Medical Group. I understand my rights outlined in the Notice in relation to the use or disclosure of my protected health information.”

(Patient Signature)

(Date)

(Printed Name)



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NOTE: A valid credit card is required to hold your appointment.

Credit Card Authorization

I, _____, authorize PhysioAge Medical Group to charge my
 (Patient Name)

MasterCard VISA AMEX Discover

for costs and fees related to my treatment program, including office visits, professional fees and medications. I understand that if I am not able to keep any appointment I must notify PhysioAge Medical Group by phone at least three (3) business days in advance or my card will be charged a non-refundable penalty equal to 50% of the cost of the consultation fee.

X

 Card holder signature Date

 Name on Card (exactly as it appears)

 Credit card number Exp. Date Security Code

 Billing Address

**PLEASE MAIL OR FAX THIS FORM TO (212)888-7828
 WITHIN THREE (3) BUSINESS DAYS IN ORDER TO KEEP YOUR APPOINTMENT.**