**MEDICAL HISTORY FORM PAGE 1**

 **PLEASE PRINT ALL INFORMATION CLEARLY**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SEX \_\_\_\_\_\_ HEIGHT\_\_\_\_\_\_\_\_AGE\_\_\_\_\_\_ WEIGHT\_\_\_\_\_\_\_ETHNICITY WHITE SPANISH ASIAN AFRO-AMERICAN OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DID YOU FIND OUT ABOUT DR. LORIA? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AFTER HAVING ARRIVED AT THE OFFICE, WHAT FORM OF IDENTIFICATION WILL YOU BE PROVIDING?**

 Driver’s License Social Security Green Card Passport Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHY HAVE YOU SCHEDULED A CONSULTATION WITH LORIA MEDICAL?**

 PENILE GIRTH ENLARGEMENT PENILE GLANS ENLARGEMENT SCROTAL ENHANCEMENT

 PEYRONIE’S OR CURVATURE CORRECTION PENILE LENGTHENING

 CORRECTION FOR PRIOR MALE ENHANCEMENT TREATMENT

 OTHER? Please explain\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL AND SURGICAL HISTORY**

* Please list all **ALLERGIES** to Medications, SULFUR, **DMSO**, IODINE, SHELL FISH, and FOOD ETC.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Have you ever had any of the following: SURGERIES:**

 Cancer  High Blood Pressure

 Stroke  HIV/AIDS

 Heart Murmurs  Rheumatic Fever

 Lung Disease Bleeding Disorders

 Heart Problems  Kidney Problems

 Blood (Anemia, etc.) Problems

 Drug or Alcohol addiction

 Herpes/other viral infections/cold sores

 Keloids/Sensitive Skin/Skin healing problems

 Epilepsy/Nervous System disorders

 Diabetes/Thyroid/ Endocrine Disease

 Gout/Joint problems

 Intestinal Problems (Ulcers, Colitis, etc.)

 Skin Cancer, Melanoma, etc.

 **OTHER MEDICAL PROBLEMS NOT LISTED HERE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL COSMETIC AND NON- COSMETIC SURGERIES YOU HAVE HAD AND IF ANY COMPLICATIONS RESULTED. PROVIDE THE YEAR/MONTH OF THE SURGERY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU CURRENTLY UNDER THE CARE OF A UROLOGIST ? DERMATOLOGIST ? IF YES PLEASE LIST: PAGE 2**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY –** Have any of your immediate family including grandparents had a Medical Illness or Surgical Operations? Be certain to list any disorders such as PROSTATE CANCER, TESTICULAR CANCER, OR SCROTAL SKIN PROBLEMS. If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATION HISTORY**

**What medications are you currently taking?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Have you ever had an adverse reaction to local anesthetics such as Lidocaine, DMSO, Marcaine, epinephrine etc., or

General anesthetics such as Nitrous Oxide (laughing gas), or any others etc.? \_\_\_\_NO if Yes Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking or have you ever taken these medications listed below?**

 \_\_**Yes**  \_\_**NO** Anti-Coagulants (Warfarin, Coumadin, Aspirin, Advil, Ibuprofen, etc.) Which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_**Yes** \_\_**NO** Accutane, Retin-A, or Isotretinoin. When was this medication last taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PROVIDE PHARMACY INFORMATION:**

PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONENUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you circumcised?** **\_\_\_Yes \_\_\_No**

**If not, Dr. Loria highly recommends that you first be circumcised prior to a penile shaft filler treatment.**

**PLEASE PROVIDE, IF ANY, ADDITIONAL MEDICAL OR SURGICAL HISTORY DETAILS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIFESTYLE HISTORY**

Have you ever smoked cigarettes? If Yes, when and how many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? If yes, how much? (Glasses per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use drugs such as cocaine, heroin, marijuana, amphetamines etc.? If Yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently an alcoholic/drug addict or recovering alcoholic/drug addict?”\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PAGE 3**

**THE PATIENT INFORMATION PROVIDED** in this form has been **truthful and accurate** to the best of his

Knowledge.The purpose of today’s consultation, or prior phone consultation, is to inform you as to which cosmetic services are available at LORIA MEDICAL and to answer any questions you may have about these services. A Medical Assistant may assist the treating Doctor in Patient care and treatment. Also, you authorize the Doctor to utilize your email address, mailing address, and telephone numbers provided for communication and charting. Please note that deposits given to hold a procedure date are only refundable up until 10-days prior to that date. The balance of the procedure cost is due on the day of the procedure.

***WARNING: ANY PATIENT TAKING VIAGRA, CIALIS, OR SIMILAR ERECTILE DYSFUNCTION MEDICATION MUST STOP TAKING IMMEDIATELY PRIOR TO ANY MALE ENHANCEMENT TREATMENTS. THIS MEDICINE, IN COMBINATION WITH CERTAIN PRESCRIBED MEDICATIONS GIVEN BY DR. LORIA, MAY CAUSE A SEVERE DROP IN BLOOD PRESSURE, LIGHTHEADEDNESS OR FAINTING.***

 **X Please sign here to acknowledge your understanding of the above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TODAY’S CONSULTATION**

The Consultation today may incur a cost of $75; however, at the end of the Consultation, the Doctor will determine whether or not, if you are eligible***, to waive the fee***.

 **X Please sign here to acknowledge your understanding of the above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIVACY FORMS and EMAIL AUTHORIZATION OF USE**

Please SIGN BELOW to acknowledge that you have read the **NOTICE OF PRIVACY FORM,** FILLED OUT THE TOP PORTION OF THE **PATIENT RECORD OF DISCLOSURE** FORM, and grant the treating Doctor authorization to

 Communicate with you electronically which includes email, texting, and the like.

 **X Please sign here to acknowledge your understanding of the above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENTS UNDER THE AGE OF 18 YEARS, THE PARENT OR GUARDIAN**

 **STATES THAT THE PATIENT’S INFORMATION PROVIDED** in this form has been **truthful and accurate** to

 the best of His or Her knowledge.

 **X Please sign here to acknowledge your understanding of the above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**