

Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

- | | | | |
|--|----|--|---|
| ☐ I am sexually active. | OR | ☐ I want to be sexually active. | ☐ I do not want to be sexually active. |
| ☐ I have completed my family. | OR | ☐ I have NOT completed my family. | |
| ☐ My sex life has suffered. | OR | ☐ I have not been able to have an orgasm or it is very difficult. | |

Habits:

- | | | |
|--|---|--|
| ☐ I smoke cigarettes or cigars _____ per day. | ☐ I use e-cigarettes _____ a day. | ☐ I use caffeine _____ a day. |
| ☐ I drink alcoholic beverages _____ per week. | ☐ I drink more than 10 alcoholic beverages a week. | |

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other _____

Pertinent medical/surgical history:

- | | |
|---|---|
| ☐ Cancer (type):
Year: _____ | ☐ Testicular or prostate cancer |
| ☐ Elevated PSA | ☐ Prostate enlargement or BPH |
| ☐ Trouble passing urine | ☐ Kidney disease or decreased kidney function |
| ☐ Taking medicine for prostate or male-pattern balding | ☐ Frequent blood donations |
| ☐ History of anemia | ☐ Non-cancerous testicular or prostate surgery |
| ☐ Vasectomy | ☐ Severe snoring |
| ☐ Erectile dysfunction | ☐ Taking medicine for high cholesterol |

Birth Control Method:

- ☐ Not applicable
- ☐ None - planning pregnancy in the next year
- ☐ Depend on partner's contraception
- ☐ Vasectomy
- ☐ Condoms
- ☐ Other: _____

Activity Level:

- ☐ Low - sedentary
- ☐ Moderate - walk/jog/workout infrequently
- ☐ Average - walk/jog/workout 1 to 3 times per week
- ☐ High - walk/jog/workout regularly 4+ times per week

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- | | |
|--|--|
| ☐ High blood pressure or hypertension | ☐ Stroke and/or heart attack |
| ☐ Heart disease | ☐ HIV or any type of hepatitis |
| ☐ Atrial fibrillation or other arrhythmia | ☐ Hemochromatosis |
| ☐ Blood clot and/or a pulmonary embolism | ☐ Psychiatric disorder |
| ☐ Depression/anxiety | ☐ Thyroid disease |
| ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis) | ☐ Diabetes |
| ☐ Arthritis | ☐ Thyroid disease |
| ☐ Hair thinning | ☐ Lupus or other autoimmune disease |
| ☐ Sleep apnea | ☐ Other _____ |
| ☐ High cholesterol | |

MALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____

EMAIL: _____

TODAY'S DATE: _____

PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

Symptoms	None	Mild	Moderate	Severe	Very Severe
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of “zest for life,” feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Sexual Desire or Performance (reduced or diminished)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Ejaculations (infrequent or absent)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss, rapid or thinning	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

[illegible]

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HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and submit for reimbursement.

Signature: _____ Date: _____

Name: _____ Date of birth: _____

PELLET INSERTION CONSENT FOR MALES

My physician/practitioner has recommended testosterone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low testosterone levels. The following information has been explained to me prior to receiving the recommended testosterone therapy.

OVERVIEW

Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

RISKS/COMPLICATIONS

Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications: acne, anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or male pattern baldness, increased growth of prostate and prostate tumors which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, increase in neck circumference, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter. If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

CONSENT FOR TREATMENT:

I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits. I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered.

I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets. I have read or have had this form read to me.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

Print name: _____ Signature: _____ Date: _____