Female New Patient Package

The contents of this package are your first step to restore your vitality. Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical can help you live ahealthier life.

Please complete the following tasks before your appointment:

Two weeks or more before your scheduled consultation have your blood lab drawn at any Quest Laboratory or LabCorp Lab. **Please fast 12 hours prior to your blood draw.**

IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY BLOOD DRAWS.

We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to.

Note: it can take up to two weeks for your lab results to be received by our office.

Your blood work panel MUST include the following tests:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total
___ TSH
___ T4, Total
___ T3, Free
___ T.P.O. Thyroid Peroxidase
___ CBC
___ Complete Metabolic Panel
___ Vitamin D, 25-Hydroxy
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Male Post Insertion Labs Needed at 4 Weeks:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total (If PSA was borderline on first insertion)
___ CBC
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
___ TSH, T4 Total, T3 Free, TPO (**Only needed if you've been prescribed thyroid medication**)

Female Patient Questionnaire & History

Name: _____Today's Date: _____
(Last) (First) (MI)

Date of Birth:_____Age:_____Weight:_____Occupation:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-mail Address: _____

May we contact you via E-mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've 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.

Spouse's/Significant Other Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No. If yes, please explain:

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information:

Preventative Medical Care:

( ) Medical/GYN exam in the last year
( ) Mammogram in the last 12 months
( ) Bone density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

( ) Breast cancer
( ) Uterine cancer.
( ) Ovarian cancer.
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy removal of ovaries.

Birth Control Method:

( ) Menopause
( ) Hysterectomy
( ) Tubal ligation.
( ) Birth control pills
( ) Vasectomy
( ) Other:

Medical Illnesses:

( ) Polycystic Ovary Syndrome (PCOS)
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric disorder
( ) Cancer (type):

Year: _____

Health Assessment For Women

Name: _____ **Date:** _____

E-mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	YES	NO
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth Control Pill Hysterectomy IUD Menopause Tubal Ligation Vasectomy

Other_____

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement.

Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE:

Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name	Signature	Today's Date