NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____
(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a personal history of? **Check all that apply.**

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
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) 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: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

AMS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*
For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2.	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4.	**Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9.	**Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13.	**Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address._____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?_____

_____

_____**Recent PSA:**_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details._____

_____

FOR OFFICE USE ONLY

CHART ID:_____**DOB:**_____**APPT DATE:**_____

Rev Jan 2022

All About Health
www.allabouthealth.com

Name: _____ Date of birth: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

All About Health®

Consent for Treatment

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 all information that might reasonably be considered relevant to decisions made by Physicians 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 sustained because 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 I sustain because 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 immediate 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 Physicians 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.

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.

Print Name: _____

Signature: _____

Date: _____

All About Health®

Consent for Intramuscular (IM) Injection Therapy

Your healthcare practitioner feels you may benefit from receiving Intramuscular (IM) vitamin injections. You have been diagnosed with or have an increased risk of having and/ or developing nutritional deficiencies, fatigue, weakness, muscular aches, or general tension/ stress which may be associated with your specific condition. The use of this therapy as it relates to your condition is considered an alternative treatment and has not been evaluated or approved by the Food and Drug Administered (FDA).

You have the right, as a patient, to be informed about your condition and the recommended alternative or non-conventional procedures to be used so that you may make an informed decision to undergo this procedure. This disclosure is meant to inform you of the benefits and any potential risks that could occur.

Your practitioner may order a variety of vitamin injections, alone or in combination. A full list of ingredients and exact dosages is available at your request.

Potential practitioners may order a variety of vitamin injections: Some individuals, based on clinical criteria, may have a nutritional deficiency, fatigue, or the need for physiological enhancement due to poor diet, disease, illness, infection, increased metabolism, or the need to alleviate stress or muscular tension. Administration of nutrient nutrient and vitamin IM injections can achieve more efficient delivery and achieve higher levels of absorption than taking oral supplements and greatly reduce the risk of gastrointestinal side effects that frequently occur with oral consumption. A standard vitamin IM injection includes vitamins, minerals, and amino acids such as Vitamin B12, Vitamin B6, Vitamin B Complex, Chromium, Adenosine, Magnesium, GABA; with potential additions/ subtractions per healthcare practitioner recommendation.

Potential Risks of IM Vitamin Injections: As with any injection, discomfort at the needle insertion site, allergic reaction, redness, irritation, bruising, or localized infection may occur. On rare occasions, some individuals may experience dizziness, lightheadedness or nausea immediately following an injection; this is a common nervous system response and passes quickly.

Contraindications of (IM) Vitamin Injections: May include bleeding disorders, pregnancy, chemotherapy, cancer history and certain allergies and are evaluated on an individual basis. Patient Statement: I agree to comply with any testing that may include laboratory or other diagnostic testing requested by my healthcare provider any adverse reaction or problem that may be related to my therapy or if I suspect I am pregnant. I understand the potential risks and benefits of the therapy and they have been explained to me, and all my questions have been adequately answered. I understand that I have not been guaranteed or promised any specific benefit to the administration of therapy.

I attest that I have read this form, or had it read to me and I agree to the treatment recommended and I will not undergo any treatments that I do not fully understand.

Print Name: _____

Signature: _____

Date: _____

MALE TESTOSTERONE PELLET INSERTION CONSENT FORM

Bio-identical hormone pellets are concentrated hormones biologically identical to the hormones you make in your own body. Testosterone is derived from the testicles (primarily) and adrenal glands (secondarily) prior to andropause.

Testosterone supplementation, in the medical research, has been shown to improve fatigue, exercise intolerance, muscle tone, libido, weight, and other conditions. It has been shown in research studies to decrease the risk of cardiovascular disease, diabetes, metabolic syndrome and prostate cancer.

Though laboratory assays can support a diagnosis of testosterone deficiency, they should not be used to exclude it as there are multiple problems in the measurement of testosterone (ex. dietary intake, sexual activity, sample storage variables, circadian variations). Greater reliance on the clinical features and consideration of symptoms is suggested as an appropriate tool in treating men with testosterone therapy. The generally accepted cutoff for low "normal" serum total testosterone is 300 ng/dl. It is reasonable to prescribe testosterone to a man who has symptoms of low testosterone and to expect testosterone values that are supraphysiologic after treatment.

All testosterone use in men with a serum level of less than 300 ng/dl is considered "off label use". Off-label use refers to the use of any medication for something other than its FDA approval. Many medications prescribed in the US are prescribed for off-label use. The off-label use of testosterone therapy has not been evaluated by the FDA and any claims of benefit are purely educated opinions that come from consideration of various medical research studies.

Hormone pellet production is highly FDA regulated; however, the pellet insertion procedure is not an FDA approved procedure for hormonal replacement in the pellet doses we use for men (200 mg pellet).

Goals for treatment with this medication will be discussed at each appointment. If goals are met, then maintenance doses will be discussed. If the treatment is not as effective as anticipated, it might be discontinued; at that time, alternative therapies will be discussed. You are welcome to seek a second opinion or a specialist consultation.

SIDE EFFECTS: Side effects of subcutaneous hormone pellets will be managed clinically and individually. There have been no reported *irreversible* side effects of subcutaneous pellet therapy noted in the literature to date.

Potential side effects of pellet insertion may include, but not limited to: Surgical risks are the same as for any minor medical procedure. Bleeding, bruising, swelling, and pain; extrusion of pellets; infection or abscess formation; seroma formation; scarring at insertion site; keloid scar.

Potential side effects of testosterone therapy may include, but are not limited to:

> Hyper-sexuality (overactive libido), increase one's hemoglobin and hematocrit (erythrocytosis), acne, increase in body/facial hair growth, hair loss/thinning and virilization, testicular shrinkage, and reduction of sperm production that may take up to a year or more to normalize to baseline.

Evidence linking testosterone therapy to the development of prostate cancer has not been established. There is some risk, even with natural testosterone therapy, of stimulating an *existing* prostate cancer to grow more rapidly. Following the American Urological Association recommendations for the evaluation and management of testosterone deficiency, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy in men over 40 and annual labs may be required at the discretion of your healthcare provider. If there is concern about possible prostate cancer, additional testing and/or follow up with specialist may be required.

CONSENT FOR TREATMENT: I have been informed that I may experience any of the complications related to this procedure. Periodic adjustments are required to fine tune the treatment with this type of medication. Periodic blood tests are necessary to determine if the dose needs to be adjusted. I understand that testosterone supplementation is available in several forms including cream, oral formulation, injections and subcutaneous pellets. I understand that I am consenting to testosterone therapy for off label use of my symptoms if my baseline serum testosterone levels are over 300ng/dl. I understand the hormone pellet procedure is not FDA approved.

AFTERCARE: I agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of hormone and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of hormone therapy. I accept these risks and benefits and I consent to the insertion of hormone pellets with a dosage regime discussed thoroughly by my hormone pellet provider.

I have read and understand this document in its entirety and have been given the opportunity to ask questions concerning my care. I consent to subcutaneous hormone pellet insertion. **This consent is ongoing for this and all future subcutaneous hormone pellet insertions.**

Patient Name	**Patient Signature**	**Date**

References:

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Lucas-Herald, A. K., Alves-Lopes, R., Montezano, A. C., Ahmed, S. F., & Touyz, R. M. (2017). Genomic and non-genomic effects of androgens in the cardiovascular system: clinical implications. Clinical Science, 131(13), 1405-1418.

Chistiakov, D. A., Myasoedova, V. A., Melnichenko, A. A., Grechko, A. V., & Orekhov, A. N. (2018). Role of androgens in cardiovascular pathology. Vascular health and risk management, 14, 283.

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Jones, T. Hugh, and Daniel M. Kelly. "Randomized controlled trials–mechanistic studies of testosterone and the cardiovascular system." Asian journal of andrology 20.2 (2018): 120

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Male Post Insertion Instructions

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage in 24 hours. It **MUST** be removed as soon as it gets wet. You may replace it with a bandage to catch any anesthetic that may ooze out. The inner layer is a steri-strip. It should not be removed before **7 days**. If the steri-strip comes off you may replace it with a band-aid.
- Do not take tub baths or get into a hot tub or swimming pool for 5-7 days. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- If you had your insertion above the belt line, no major back muscle exercises for the next 7 days; this includes any repetitive movements that would stretch/stress/twist the insertion area including tennis, golf, side-bends, etc.
- If you had your insertion below the belt line, no major gluteal exercises for the next 7 days; this includes running, squats, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

REMINDERS

- **New patients - VERY Important!**
    - Please go for your post-insertion blood work 4 weeks after your initial pellet insertion.
    - Please schedule a lab review appointment 5 weeks after your initial pellet insertion so we can review your post-insertion lab results. There is no charge for this office visit.
- On average, males need pellet insertions every **5 months** after their initial insertion.
- Please call to make an appointment for a re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion and not a consultation.

Print Name_____**DOB**_____**Signature**_____**Date:**_____