MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____Today's Date: _____

Date of Birth: _____Age:_____Weight:_____Occupation:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Local Pharmacy: _____ Mail Order: _____

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

In the event we cannot contact you by the means 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.

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.

Exercise:

☐ Never ☐ Sporadic ☐ 3-4x/wk ☐ Daily

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: _____

Other Pertinent Information: _____

_____

Medical Illnesses:

☐ High blood pressure.
☐ High cholesterol.
☐ Heart Disease.
☐ Stroke and/or heart attack.
☐ Blood clot and/or a pulmonary embolus.
☐ Hemochromatosis.
☐ Depression/anxiety.
☐ Psychiatric Disorder.
☐ Cancer (type): _____
Year: _____

☐ Testicular or prostate cancer.
☐ Elevated PSA.
☐ Prostate enlargement.
☐ Trouble passing urine or take Flomax or Avodart.
☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis).
☐ Diabetes.
☐ Thyroid disease.
☐ Arthritis

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.
By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ _____
Print Name Signature Today's Date

HEALTH ASSESSMENT FOR MEN

Name: _____ **Date:** _____

E-Mail: _____

Symptom (*please check mark*)	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed you peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight gain/Belly fat/Inability to lose weight				
Breast development				
Shrinking testicles				
Rapid hair loss				
Decrease in beard growth				
New migraine headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or absent ejaculations				
No results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Prostate Exam Waiver for Testosterone Therapy

I, (patient name)_____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone pellet therapy with, Plano Wellness, Dr. Marlene Diaz.

Testosterone has not been shown to cause prostate cancer but there is a chance that supplementation can accelerate tumor growth of some prostate cancers. A prostate exam is the best single method for detection of early prostate cancer. Your prostate should be examined by your primary care physician yearly. The role of your hormone therapy Treating Provider does not include primary care.

My Treating Physician has not performed a prostate exam. I agree that I am and will be under the care of another physician for primary care and other medical conditions. My Treating Physician has discussed the importance and necessity of prostate exam since I receive testosterone supplement therapy.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to undergo testosterone therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Treating Provider and any of their medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____	_____	_____
Print Name	Signature	Today's Date

WHAT MIGHT OCCUR AFTER A PELLET – MALE

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- **SWELLING of the HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

- **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.

- **FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

- **HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

_____ _____ _____

Print Name Signature Today's Date

MALE NEW PATIENT CONSULT

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 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. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life.

IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY BLOOD DRAWS. Please note that it can take up to two weeks for your lab results to be received by our office. Please fast for 12 hours prior to your blood draw.

Your blood work panel MUST include the following tests:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total
___ TSH
___ T4, Free
___ T3, Free
___ Thyroid Peroxidase & Thyroglobulin antibodies
___ CBC
___ Complete Metabolic Panel
___ HgbA1c
___ Vitamin D
___ Vitamin B12
___ Prolactin
___ DHEA-S
___ Ferritin
___ Lipid Panel with LDL fractionation (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, Free T4, T3 Free (**Only needed if you've been prescribed thyroid medication**)

Male Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio-identical hormone pellets are plant derived and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Risks of not receiving testosterone therapy after andropause include but are not limited to: Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. Surgical risks are the same as for any minor medical procedure.

Side effects may include: Bleeding, bruising, swelling, infection, pain, reaction to local anesthetic and/or preservatives, lack of effect (typically from lack of absorption), thinning hair, male pattern baldness, increased growth of prostate and prostate tumors, extrusion of pellets, hyper sexuality (overactive libido), ten to fifteen percent shrinkage in testicle size and significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. 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 and 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 (secondary to hormonal decline); decreased weight (increase in lean body mass); decrease in risk or severity of diabetes; decreased risk of Alzheimer's and dementia; and decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may 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 bio-identical 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 bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 insertions.

I understand that payment is due in full at the time of service. I have been advised that most insurance companies do not consider compounded hormone pellet therapy to be a covered benefit. I am aware that while there may be some insurance companies that allow for the insertion, itself. My charge today is for the compounded medication which is generally not covered by insurance.

_____ _____ _____

Print Name Signature Today's Date

POST-INSERTION INSTRUCTIONS FOR MEN

- Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip and the outer layer is a gauze and tape dressing.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue for swelling if needed. *Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.*
- No tub baths, hot tubs, or swimming pools for **7 days**. You may shower, but do not scrub the site until the incision is well healed (about 7 days).
- **No major exercises for the incision area for 7 days.** This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and walking.
- 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 bleeding (not oozing) not relieved with pressure, as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

- Remember to go for your post-insertion blood work **5 weeks** after the insertion.
- Most men will need re-insertions of pellets **5-6 months** after the initial insertion.

As soon as symptoms that were relieved from the pellets start to return, please go for labs and schedule your appointment for re-insertion the following week.

Additional medications which may be recommended:

Thyroid supplement This should be taken every morning with water on an empty stomach. Please wait 30 minutes before eating or drinking anything other than water. This includes coffee, food, medications, vitamins or supplements.

Spironolactone This is best taken in the mornings though not with a thyroid supplement. This is a mild diuretic. It is acceptable to skip a dose if you will not have access to water or will be outdoors with a risk of dehydration.

I acknowledge that I have received a copy and understand the instructions on this form.

_____ _____ _____

Print Name Signature Today's Date

REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN

I request that **Plano Wellness PLLC** (the "Practice") not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law.

The records of the restricted services/items listed below ("Restricted Services/Items") will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations.

I understand I am financially responsible for these Restricted Services/Items and will pay out-of-pocket, in full, at the time of service in order for the Practice to accept this restriction request.

REQUESTED RESTRICTION:
Services/Items to be restricted:
Consultation and or treatment for symptoms consistent with low testosterone.
_____

Other:
_____

_____

(I understand that I am responsible for full charges when finalized)

Signed by: _____ Date: _____

PRACTICE USE ONLY:

Print Patient Name: _____

Print Patient Address: _____