BioSana ID

INDIVIDUALLY DESIGNED WELLNESS

BioSana ID Female Patient Packet

Thank you for your interest in BioSana ID. To determine if you are a candidate for Bio-Identical hormone pellets, we need lab test and medical history forms. We will evaluate your information prior to your consultation to determine if BioSana ID can help you live a healthier life.

Prior (2 weeks) to your scheduled consultation, you will need to get your lab drawn at any Clinical Pathology Laboratory (CPL) lab. If you are not insured or have a high deductible, call our office for self-pay blood draw discounts. We need the test listed below to determine if you are a candidate. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. Please note that it can take 7 to 10 days for your lab results to be received by our office.

Your lab must include the following test for a Pre and Post Female Panel:

_____ DHEA Sulfste

_____ Estradiol

_____ Estrone (E 1)

_____ FSH

_____ LH

_____ Progesterone

_____ Testosterone

- Free Testosterone (Calculated)
- Sex Hormone Binding Globulin

Post labs needed at 6 weeks. Repeat panel above.

Female Patient Questionnaire & History

Name: _____ Today's Date: _____

(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-mail Address: _____ May we contact you via E-Mail? ( ) Yes ( ) No

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone Number: _____

Address: _____

Address City State Zip Code

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

In the event we cannot contact you by the means of your provided information 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 Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social History:

( ) I smoke (cigarettes or cigars) _____ per week/week.

( ) I drink alcoholic beverages _____ drinks, _____ times per week.

( ) I use caffeine, _____ cups per day.

( ) I am sexually active.

( ) I have completed my family.

Medical History

Any known drug/environmental (i.e. tape/adhesive) 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 cycle (estimate year if unknown): _____

Other Pertinent Information: _____

Presentative Medical Care:

Date of last pap smear: _____

Date of last mammogram: _____

Date of last Bone Density: _____

Do you have a history of:

( ) Breast Cancer

( ) Uterine Cancer

( ) Ovarian Cancer

( ) None of the above

Have you had:

( ) Hysterectomy with removal of ovaries

( ) Hysterectomy (removal of uterus only)

( ) Oophorectomy (removal of ovaries only)

Birth Control Method:

( ) Menopause

( ) Hysterectomy

( ) Tubal Ligation

( ) Birth Control Pills

( ) Vasectomy

( ) Other: _____

Please mark any **Medical Illnesses:**

( ) High Blood pressure

( ) Heart bypass

( ) Hight 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

( ) Chromic 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	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Mental confusion	_____	_____	_____	_____
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 is 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	_____	_____

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Breast Cancer Waiver for Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical estradiol pellet therapy, even though I have a history of breast cancer. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contradicted. My Treating Provider has informed me is it possible that taking Estradiol could possibly cause cancer or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I acknowledge that I bear full responsibility for nay personal injury or illness, accident, risk or loss (including death and/or cancer issues) that may be sustained by me in connection with my decision to undergo estradiol pellet therapy including, without limitation, and 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 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 results of testosterone pellet 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.

_____	_____	_____
Patient Print Name	Patient Signature	Date

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INDIVIDUALLY DESIGNED WELLNESS

Ovarian Cancer Waiver for Testosterone and/ or Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical estradiol pellet therapy, even though I have a history of ovarian cancer. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contradicted. My Treating Provider has informed me is it possible that taking Testosterone and/or Estradiol could possibly cause cancer or stimulate existing ovarian cancer (including one that has not yet been detected). Accordingly, I am aware that ovarian cancer or other cancer could develop while on pellet therapy.

I have assessed this risk on a personal basis, and m perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I acknowledge that I bear full responsibility for nay personal injury or illness, accident, risk or loss (including death and/or cancer issues) that may be sustained by me in connection with my decision to undergo Testosterone and/or Estradiol pellet therapy including, without limitation, and 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 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 results of testosterone pellet 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.

_____	_____	_____
Patient Print Name	Patient Signature	Date

BioSanaD
INDIVIDUALLY DESIGNED WELLNESS

PAP and Transvaginal Ultrasound Waiver for Testosterone and/or Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy.

( ) For today's appointment I DO NOT have a PAP smear for the following reason:

( ) My decision not to have one.

( ) Unable to provide the report at this time.

( ) My doctor's decision not to have one. Please provide note from your treating physician with their rationale as to why they don't want you to have a PAP smear.

( ) For today's appointment I DO NOT have a Transvaginal Ultrasound for the following reason:

( ) My decision not to have one.

( ) Unable to provide the report at this time.

( ) My doctor's decision not to have one. Please provide note from your treating physician with their rationale as to why they don't want you to have a Transvaginal Ultrasound.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a Pap smear and/or Transvaginal Ultrasound since I receive testosterone and/or estradiol. _____ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that PAP smear and/or Transvaginal Ultrasounds are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a PAP smear and Transvaginal Ultrasound may results in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer issues) that may be sustained by me in connection with my decision to not have a PAP smear and/or Transvaginal Ultrasound and undergo testosterone and/or estradiol pellet 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 _____ 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 and/or estradiol pellet 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.

_____	_____	_____
Patient Printed Name	Patient Signature	Today's Date

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Mammogram Waiver
for Estradiol and Testosterone Pellet Therapy

I, _____ voluntarily choose to undergo implantation of subcutaneous
(Patient Name)

Bio-identical Estradiol & Testosterone pellet therapy with_____.
(Treating Provider)

For today's appointment, I **do not** have a Mammogram Report for this reason:

☐ My decision not to have one.
☐ My doctor's decision to not have one, Dr. _____ Please provide a note from the aforementioned physician outlining the rationale.

☐ Unable to provide report at this time.

Mammogram report information:
Date of mammogram report: _____
My Results were: ☐ Normal ☐ Abnormal

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive estrogen. _____ (initials of patient)

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast or uterine issues) that may be sustained by me in connection with my decision to refrain from obtaining a mammogram exam. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless Treating Physicians; _____ 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 my refusal to undergo a mammogram exam. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

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 14th, 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 regulations on who may see or be notified of your Protect 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 and 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 yo other communications information 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 you 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.

_____	_____	_____
Print Name	Signature	Date

11/2018

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Informed Consent

Please make certain to review the information provided on the consent form

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes may 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 – is common in hot and humid weather. It may be treated by drinking plenty 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 requires a prescription.

Breast Tenderness/Nipple Sensitivity – May develop with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. This increases in blood supply is a good thing, as it nourishes the tissue. To combat the tenderness, you may take a capsule of oil of Evening Primrose of Prim Royal 2 -3 times daily. You may need to take them for 2 – 3 weeks.

Uterine Spotting/Bleeding – May occur in the first few months after an estrogen pellet insertion, especially if your progesterone is not taken properly (i.e. missing doses, or not taking a high enough dose). Please notify us if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that need to be eliminated. This tissue may have already been present in your uterus prior to getting the pellets and is being released in response to the increase in hormones.

Mood Swings/Irritability – May occur if you were quite deficient in hormones. They should disappear when enough hormones are in your system.

Acne – May arise if the body is very deficient in testosterone. This usually 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 our office,

Hair loss – Is rare and usually occurs in patients who concert testosterone to DHT (dihydrotestosterone). Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

Hair Growth – Testosterone may stimulate some growth of hair on your chin, chest, nipples, and/or lower abdomen. This tends to be hereditary. Dosage adjustment usually reduces or eliminates the problem.

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Sperm Suppression – An additional concern, especially in younger men, is the suppression of the development of sperm and the sperm count with a dramatic reduction while a person is on testosterone therapy.

Infection – Is possible, though unusual. Should an infection occur, additional treatment including antibiotics may be necessary.

Anesthesia – Both local and general anesthesia involve risk. This is a possibility of complications, injury, and even death from all forms of anesthesia. PLEASE NOTIFY STAFF IF YOU HAVE EVER HAD COMPLICATIONS RELATED TO ANESTHESIA.

I understand the reason for the procedure is hormone replacement therapy using Estradiol and/or Testosterone. No guarantee or assurance has been made as to the results of the procedure and I am aware that it may not cure any condition I may have. I have read the above and understand the risks of the procedure. All my questions have been answered to my satisfaction.

_____

Print Name

_____ _____

Signature Date

_____

Witness (Staff)

WHAT MIGHT OCCUR AFTER A PELLEET INSERTION (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.

UTERINE SPOTTING/BLEEDING: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking in properly; i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

MOOD SWINGS/IRRITABILITY: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchase at many health food stores.

FACIAL BREAKOUTS: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can handled with a good face cleanings 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 eliminate the problem. Prescription medications may be necessary in rare cases.

HAIR GROWTH: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

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

_____	_____	_____
Print Name	Signature	Today's Date