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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 a healthier life. **Please complete the following tasks before your appointment:**

2 weeks or more before your scheduled consultation: Get your blood lab drawn at any Quest Laboratory/ or LabCorp Lab. 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. **Please note that 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
___ FSH
___ Testosterone Total
___ TSH
___ T4, Total
___ T3, Free
___ T.P.O. Thyroid Peroxidase
___ CBC
___ Complete Metabolic Panel
___ Vitamin D, 25-Hydroxy (Optional)
___ Vitamin B12 (Optional)
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

___ FSH
___ Testosterone Total
___ CBC
___ Lipid Panel (Optional) (**Must be a fasting blood draw to be accurate**)
___ TSH, T4 Total, T3 Total, TPO (**Needed only if you've been prescribed thyroid medication**)

Female Patient Questionnaire & History

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

Date of Birth: _____ Age: _____ 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: _____
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 Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

Habits:

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

Medical History

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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:

( ) 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: _____

BHRT CHECKLIST FOR WOMEN

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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 is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

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

Bio-identical hormone pellets are concentrated 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 made from yam 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 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.**

Side effects may include: Bleeding, bruising, swelling, infection and pain; 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); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; 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 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. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

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 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 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 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**

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Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	**$125.00**
Female Hormone Pellet Insertion Fee	**$300.00**

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, Personal Checks and Cash.

_____ _____ _____

Print Name **Signature** **Today's Date**

OFFICE USE ONLY FEMALE INTAKE FORM

NAME: _____ DATE: _____

Height: _____ Weight: _____Blood Pressure: _____Temperature: _____

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CURRENT MEDICATIONS: _____

SURGERY/ HISTORY: **Hysterectomy**: ( ) **YES** ( ) **NO** **Ovaries**: ( ) **YES** ( ) **NO**

Last Pap: _____ **Last Mammogram**: _____ **Normal**: ( ) **YES** ( ) **NO**

_____

SYMPTOMS:_____

_____

LABS:

Estradiol: _____ Testosterone: _____ FSH: _____ Vitamin D: _____ Vitamin B12: _____

TSH: _____ Free T3: _____ TPO: _____ CBC: _____ Chem Panel: _____

LDL: _____ HDL: _____ Triglycerides: _____

PLAN:
This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Betadine swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips and/or Foam Tape were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient. Pellets used are as follows:

TREAT WITH:

1. **Testosterone**: _____ MG's **Testosterone Lot Numbers**: _____
2. **Estradiol**: _____ MG's **Estradiol Lot Numbers**: _____
3. **Progesterone**: _____ **CYCLE** or **CONTINUOUS** (circle one)
4. **Femara**: _____ **Arimidex**: _____ **DIM**: _____
5. **Vitamin ADK**: _____ **Thyroid**_____ **Iodine** _____
6. **Evening Primrose**: _____
7. **Other**: _____

COMMENTS:_____

_____

_____

OFFICE USE ONLY FEMALE PATIENT TREATMENT FORM

NAME: _____

DATE _____

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SYMPTOMS/NOTES:

_____

_____

PROCEDURE REPORT:

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Betadine swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and/or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips and/or Foam Tape were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient.

Weight _____ Estrogen pellet Lot # _____ Testosterone pellet Lot # _____

Estradiol _____ mg Testosterone _____ mg

Insertion site: Left Hip ( ) Right Hip ( )

DATE _____

SYMPTOMS/NOTES:

_____

_____

PROCEDURE REPORT:

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Betadine swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and/or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips and/or Foam Tape were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient.

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Estradiol _____ mg Testosterone _____ mg

Insertion site: Left Hip ( ) Right Hip ( )