



Male 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. 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, 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)**



Male Patient Questionnaire & History

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

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: _____
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.
- () 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.

Focused Review of Systems:

- *Circle any of the following symptoms you've experienced in the past 12 months.*
- Neck Pain Back Pain Knee Pain
 - Dizziness Unexpected Weight Loss
 - Blurred Vision Difficulty Swallowing
 - Chest Pain Shortness of Breath
 - Constipation Painful Urination
 - Anxiety/Depression



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:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure. | <input type="checkbox"/> Testicular or prostate cancer. |
| <input type="checkbox"/> High cholesterol. | <input type="checkbox"/> Elevated PSA. |
| <input type="checkbox"/> Heart Disease. | <input type="checkbox"/> Prostate enlargement. |
| <input type="checkbox"/> Stroke and/or heart attack. | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart. |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli. | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis). |
| <input type="checkbox"/> Hemochromatosis. | <input type="checkbox"/> Diabetes. |
| <input type="checkbox"/> Depression/anxiety. | <input type="checkbox"/> Thyroid disease. |
| <input type="checkbox"/> Psychiatric Disorder. | <input type="checkbox"/> Arthritis. |
| <input type="checkbox"/> Cancer (type): _____ | |
| Year: _____ | |

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



BHRT CHECKLIST FOR MEN

Name: _____

Date: _____

E-Mail: _____

| Symptom (please check mark) | Never | Mild | Moderate | Severe |
|--|--------------|-------------|-----------------|---------------|
| Decline in general well being | | | | |
| 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 your 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 | | |



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 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



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 Evaluation Fee | \$175 |
| Self-Pay Initial Blood Draw & Labs | * |
| Self- Pay Follow-Up Blood Draw & Labs | * |
| Female Hormone Pellet Insertion Fee | * |
| Male Hormone Pellet Insertion Fee | * |
| Male Pellet Insertion Fee (≥2000mg) | * |

*covered under membership program. New patient evaluation fee will be waived for patients who sign up for the program on the day of consultation.

We accept the following forms of payment:

Master Card, Visa, Discover, American Express credit and debit cards.

Print Name
Signature

Today's Date