# 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 labs drawn at any Quest Diagnostics or LabCorp. 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, Free T3, TPO (**Needed only if you've been prescribed thyroid medication**
___ Estradiol

# Female 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.
( ) 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

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:

( ) Polycystic Ovary Syndrome (PCOS)
( ) 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: _____

# Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name:_____ Today's Date:_____

(Last) (First) (Middle)

Bio-identical hormone pellets are 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 plant derived 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 is category X (will cause birth defects) and 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 and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; 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); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; 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 & 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 have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. 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 pellet 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**

# BHRT Checklist For Women

**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 falling out | | | | |
| Cold all the time | | | | |
| Swelling all over the body | | | | |
| Joint pain | | | | |

## Family History

| | NO | YES |
|---|---|---|
| Heart Disease | | |
| Diabetes | | |
| Osteoporosis | | |
| Alzheimer's Disease | | |
| Breast Cancer | | |