Shea
AESTHETIC CLINIC

Male Checklist and Symptoms Tracker

Place an "X" for EACH symptom you are currently experiencing. Please mark only ONE box.
For symptoms that do not apply, please mark NONE.

		None	Mild	Moderate	Severe	Extremely Severe
	SCORE:	1	2	3	4	5
1.	**Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2.	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4.	**Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9.	**Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13.	**Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address._____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ☐ Physical activity that accelerates heart rate / Breathlessness

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?_____

_____**Recent PSA:**_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details._____

PT Name: _____ DOB:_____ Appt Date:_____

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MALE TESTOSTERONE PELLET INSERTION CONSENT FORM

Bio-identical hormone pellets are concentrated hormones biologically identical to the hormones you make in your own body. Testosterone is derived from the testicles (primarily) and adrenal glands (secondarily) prior to andropause.

Testosterone supplementation, in the medical research, has been shown to improve fatigue, exercise intolerance, muscle tone, libido, weight, and other conditions. It has been shown in research studies to decrease the risk of cardiovascular disease, diabetes, metabolic syndrome and prostate cancer.

Though laboratory assays can support a diagnosis of testosterone deficiency, they should not be used to exclude it as there are multiple problems in the measurement of testosterone (ex. dietary intake, sexual activity, sample storage variables, circadian variations). Greater reliance on the clinical features and consideration of symptoms is suggested as an appropriate tool in treating men with testosterone therapy. The generally accepted cutoff for low "normal" serum total testosterone is 300 ng/dl. It is reasonable to prescribe testosterone to a man who has symptoms of low testosterone and to expect testosterone values that are supraphysiologic after treatment.

All testosterone use in men with a serum level of greater than 300 ng/dl is considered "off label use". Off-label use refers to the use of any medication for something other than its FDA approval. Many medications prescribed in the US are prescribed for off-label use. The off-label use of testosterone therapy has not been evaluated by the FDA and any claims of benefit are purely educated opinions that come from consideration of various medical research studies.

Hormone pellet production is highly FDA regulated; however, the pellet insertion procedure is not an FDA approved procedure for hormonal replacement in the pellet doses we use for men (200 mg pellet).

Goals for treatment with this medication will be discussed at each appointment. If goals are met, then maintenance doses will be discussed. If the treatment is not as effective as anticipated, it might be discontinued; at that time, alternative therapies will be discussed. You are welcome to seek a second opinion or a specialist consultation.

SIDE EFFECTS: Side effects of subcutaneous hormone pellets will be managed clinically and individually. There have been no reported *irreversible* side effects of subcutaneous pellet therapy noted in the literature to date.

Potential side effects of pellet insertion may include, but not limited to: Surgical risks are the same as for any minor medical procedure. Bleeding, bruising, swelling, and pain; extrusion of pellets; infection or abscess formation; seroma formation; scarring at insertion site; keloid scar.

Potential side effects of testosterone therapy may include, but are not limited to:

Hyper-sexuality (overactive libido), increase one's hemoglobin and hematocrit (erythrocytosis), acne, increase in body/facial hair growth, hair loss/thinning and virilization, testicular shrinkage, and reduction of sperm production that may take up to a year or more to normalize to baseline.

Evidence linking testosterone therapy to the development of prostate cancer has not been established. There is some risk, even with natural testosterone therapy, of stimulating an *existing* prostate cancer to grow more rapidly. Following the American Urological Association recommendations for the evaluation and management of testosterone deficiency, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy in men over 40 and annual labs may be required at the discretion of your healthcare provider. If there is concern about possible prostate cancer, additional testing and/or follow up with specialist may be required.

CONSENT FOR TREATMENT: I have been informed that I may experience any of the complications related to this procedure. Periodic adjustments are required to fine tune the treatment with this type of medication. Periodic blood tests are necessary to determine if the dose needs to be adjusted. I understand that testosterone supplementation is available in several forms including cream, oral formulation, injections and subcutaneous pellets. I understand that I am consenting to testosterone therapy for off label use of my symptoms if my baseline serum testosterone levels are over 300ng/dl. I understand the hormone pellet procedure is not FDA approved.

AFTERCARE: 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 hormone 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 hormone therapy. I accept these risks and benefits and I consent to the insertion of hormone pellets with a dosage regime discussed thoroughly by my hormone pellet provider.

I have read and understand this document in its entirety and have been given the opportunity to ask questions concerning my care. I consent to subcutaneous hormone pellet insertion. **This consent is ongoing for this and all future subcutaneous hormone pellet insertions.**

_____ _____

Patient Name **Patient Signature**

_____**Date**

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Male Post Pellet Care

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage in 24 hours. It **MUST** be removed as soon as it gets wet. You may replace it with a bandage to catch any anesthetic that may ooze out. The inner layer is a steri-strip. It should not be removed before **7 days**. If the steri-strip comes off you may replace it with a band-aid.
- Do not take tub baths or get into a hot tub or swimming pool for 5-7 days. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- If you had your insertion above the belt line, no major back muscle exercises for the next 7 days; this includes any repetitive movements that would stretch/stress/twist the insertion area including tennis, golf, side-bends, etc.
- If you had your insertion below the belt line, no major gluteal exercises for the next 7 days; this includes running, squats, riding a horse, etc.
- 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 any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

REMINDERS

- **New patients - VERY Important!**
    - Please go for your post-insertion blood work 4 weeks after your initial pellet insertion.
    - Please schedule a lab review appointment 5 weeks after your initial pellet insertion so we can review your post-insertion lab results. There is no charge for this office visit.

- On average, males need pellet insertions every **5 months** after their initial insertion.
- Please call to make an appointment for a re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion and not a consultation.

Print Name_____DOB_____Signature_____
Date:_____

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Fee Acknowledgment

Although more insurance companies are reimbursing patients for Bio-Identical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your BHRT procedure (see fee schedule below).

New Patient Consultation Fee	$200
Lab Fee (in office)	$150
Female Hormone Pellet Insertion Fee	$350
Male Hormone Pellet Insertion Fee	$650
Male Hormone Pellet Insertion Fee (> 2000mg)	$750

Upon request, we will give you the appropriate paperwork so you can file for reimbursement with your health savings account (HSA/FSA).

Print Name _____ **Signature** _____ **Date** _____

We accept the following forms of payment

*American Express, Master Card, Visa, Discover, Checks, Cash and Cherry Financing**