NEW PATIENT QUESTIONNAIRE - Female

Name:_____DOB: _____Today's Date:_____
(Last) *(First)*

In Case of Emergency Contact:_____Relationship:_____

Cell Phone:_____ Work:_____

MEDICAL HISTORY

Height:_____Weight:_____ Age: _____

Have you had, or do you have breast cancer? ( ) Yes ( ) No Do you have fibrocystic or dense Breasts? ( ) Yes ( ) No

Currently on birth control? ( ) Yes ( ) No

Hysterectomy? ( ) Yes ( ) No Were ovaries removed? ( ) Yes ( ) No About how many years ago?_____

Menstrual cycle: ( ) Regular ( ) No periods for >12 mo ( ) Irregular [perimenopause] ( ) Irregular [birth control, PCOS, other]

Last Menstrual Period:_____ Do you have PCOS? ( ) Yes ( ) No

Do you smoke cigarettes or marijuana weekly? ( ) Yes ( ) No Do you drink alcohol weekly? ( ) Yes ( ) No

Have you had problems with acne as an adult? ( ) Yes ( ) No

Currently on testosterone therapy? ( ) Yes ( ) No Currently on estrogen therapy? ( ) Yes ( ) No

Received estrogen therapy in the past? ( ) Yes ( ) No Had a normal mammogram within the last 12 months? ( ) Yes ( ) No

Currently taking any ADD or ADHD meds (Adderall, Concerta, Vyvanse, etc.)? ( ) Yes ( ) No

Currently being treated with pain medications for chronic pain? ( ) Yes ( ) No

Low Libido? ( ) Yes ( ) No Menstrual or cyclical migraine headaches? ( ) Yes ( ) No Fatigue? ( ) Yes ( ) No

Unwanted weight gain? ( ) Yes ( ) No Frequent UTI's? ( ) Yes ( ) No Brain fog, forgetfulness? ( ) Yes ( ) No

Any drug allergies: ( ) Yes ( ) No Drug allergy details:_____

Current Medications and dosage:_____
_____
_____

Nutritional/Vitamin Supplements: _____
_____

Current Hormone Replacement Therapy:_____Past HRT: _____

Major Surgeries (list approx. year):_____

Other Pertinent Information: _____
_____
_____
_____
_____

Continue On Other Side---→

Do you have a personal history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) 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

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: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

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Female 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 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

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?

PT Name: _____ DOB:_____ Appt Date:_____

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Aesthetic Concerns & Interest

Please check any of the following concerns that apply to you. This will help us personalize your consultation.

☐ Fine lines or wrinkles
☐ Facial volume loss in cheeks, lips, or under eyes
☐ Sun damage or age spots
☐ Uneven skin tone or texture
☐ Rosacea or redness
☐ Double chin or fullness under the chin
☐ Cellulite or uneven skin dimpling
☐ Stretch marks
☐ Thinning hair or hair loss
☐ Nasal folds or marionette lines
☐ Skin laxity post-pregnancy or weight loss
☐ Concerned about aging hands or neck
☐ Wanting a more refreshed or youthful appearance overall
☐ Sagging or loose skin (face or body)
☐ Unwanted facial or body hair
☐ Acne or acne scarring
☐ Enlarged pores
☐ Dry or dull skin
☐ Oily & or Acne Prone Skin
☐ Stubborn fat pockets (abdomen, thighs, arms, etc.)
☐ Excessive sweating (underarms, hands, feet)
☐ Lip asymmetry or thin lips
☐ Desire for more contoured jawline or cheekbones
☐ Scarring from injury or surgery
☐ Interested in preventative treatments or 'prejuvenation'
☐ Urinary incontinence- urine leakage when you laugh/sneeze/cough

Any other concerns not listed previously:

_____
_____
_____
_____
_____

Thank you for completing this checklist. Your provider will review it with you during your consultation.

Provider Notes:

_____
_____
_____
_____
_____
_____

PT Name: _____ DOB:_____ Appt Date:_____

FEMALE TESTOSTERONE AND/OR ESTRADIOL PELLET INSERTION CONSENT FORM

Bio-identical hormone pellets are concentrated hormones biologically identical to the hormones you make in your own body. Estrogen, progesterone and testosterone are derived from the female ovaries (primarily) and adrenal glands (secondarily) prior to menopause.

Testosterone is a hormone produced by the ovaries and adrenal glands in women. In the medical research, testosterone supplementation in women has been shown to improve fatigue, exercise intolerance, muscle tone, libido, weight, decrease depression, anxiety and mood disorders and other conditions.

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 women with testosterone therapy. There is no generally accepted "normal" level of testosterone for women. It is reasonable to prescribe testosterone to a woman who has symptoms of low and to expect total testosterone values that are supraphysiologic after treatment.

All testosterone use in women is considered "off-label". 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. It is reasonable to expect a supraphysiologic testosterone laboratory value after pellet therapy is initiated.

Hormone pellet production is highly FDA regulated; however, the pellet insertion procedure is not an FDA approved procedure for hormonal replacement.

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.

The safety of hormone therapy 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 adverse effects in the fetus.

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.

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 the hormones may include, but are not limited to:

Estradiol Related: Dysfunctional uterine bleeding***;*** growth of estrogen dependent tumors and breast tenderness (estradiol)**.**

Testosterone Related: Hyper-sexuality (overactive libido) increase one's hemoglobin and hematocrit (erythrocytosis), acne, increase in body/facial hair growth, abnormal menstrual cycles, hair loss/thinning and virilization, voice changes or abnormal growth of the female genitals (testosterone).

17-beta estradiol has not been shown in any clinical study to date to increase breast, uterine or ovarian cancer risk; however if a patient has an undiagnosed estrogen/hormone dependent cancer a possible risk of accelerated growth may occur. For this reason mammograms, according to the current clinical guidelines, are required as a baseline prior to the initiation of hormone therapy. Every patient has a right to refuse diagnostic mammogram. ***I understand if I refuse I will be required to sign a mammogram waiver before I am to receive hormone therapy. I understand if I have a uterus and am on estradiol therapy I must take oral micronized progesterone (prescription) daily for protection against uterine cancer.***

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 hormone therapies are available in other forms including creams and oral medications. I understand that I am consenting to testosterone therapy for off label use of my symptoms. 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**

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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	$375
Male Hormone Pellet Insertion Fee	$650
Male Hormone Pellet Insertion Fee (> 2000mg)	$750
Lab Follow-Up Visit (No Pellet)	$50

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**

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AESTHETIC CLINIC

Female Post Pellet Care

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 3 to 4 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 either waterproof foam tape or steri-strips. They should be removed in **3 days**. If the tape or 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 **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **4 days**, this includes running, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days. This is normal.
- 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 oozing) or pus coming out of the insertion site that is not relieved by pressure.

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, females need pellet insertions every **4 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.

What Might Occur- Female Only

A significant hormonal transition will occur in the first 3-6 weeks after beginning your BHRT regime. 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 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.

FACIAL BREAKOUT: Some pimples may arise if the body is very deficient in testosterone. This 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 the office for suggestions and possibly prescriptions.

HAIR THINNING: Is VERY rarely caused by the addition of hormones, including testosterone. More often a woman's hair has been thinning or dormant for a long time because of the lack of hormones. Once hormone therapy begins, the hair follicles wake up and begin to do their job- shed old hair and grow new hair. This can last several weeks and be very disconcerting, but rest assured it is normal and is a sign of healthy metabolism. Supplements and over the counter topical Rogaine helps slow down the shed stage and

may be helpful. Your provider may also have other topical options available during this transition to lessen the shedding.

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 may reduce the problem but rarely will eliminate it.