# PATIENT INTAKE FORM

## PATIENT INFORMATION

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Weight:_____ Occupation:_____

Sex: ☐ Male ☐ Female ☐ Prefer not to Share

Marital Status (Check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Preferred Contact Number:_____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email Address:_____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Care Physician's Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

In the event we cannot contact you by the means you have 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 to your spouse or significant other about your treatment.

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

## PATIENT HISTORY

**Social:**

☐ I am sexually active **OR** ☐ I want to be sexually active **OR** ☐ I do not want to be sexually active

☐ I have completed my family **OR** ☐ I have not completed my family

☐ My sex life has suffered **OR** ☐ I have not been able to have an orgasm or it is very difficult

**Habits (Select all that apply):**

☐ I smoke cigarettes or cigars____per day.

☐ I use e-cigarettes____a day.

☐ I use caffeine

☐ I drink alcoholic beverages____per week.

☐ I drink more than 10 alcoholic beverages a week.

# PATIENT INTAKE FORM

## PATIENT INFORMATION (Continued)

**Drug Allergies:**

Drug Allergies: ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No

Medication currently taking: _____

Current hormone replacement? ☐ Yes ☐ No

If yes, what? _____

Past hormone therapy: _____

**Family History (Select all that apply):**

☐ Heart Disease

☐ Diabetes

☐ Osteoporosis

☐ Alzheimer's/Dementia

☐ Breast Cancer

☐ Other

**Activity Level (Select all that apply):**

☐ Low (Sedentary)

☐ Moderate (Walk/jog/workout infrequently)

☐ Average (Walk/jog/workout 1 to 3 times per week)

☐ High (Walk/jog/workout regularly 4+ times per week)

# BIOTE FEMALE HEALTH HISTORY & SYMPTOMS

## PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

## PATIENT QUESTIONS

Currently pregnant or trying to conceive? ☐ Yes ☐ No

Date of last mammogram: _____

Had menstrual cycle (within last 12 months)? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Had endometrial ablation? ☐ Yes ☐ No

Is the patient on birth control? ☐ Yes ☐ No Name of birth control: _____

Has the patient had a hysterectomy? ☐ Yes ☐ No

If so, type of hysterectomy: ☐ Complete (uterus and ovaries removed) ☐ Partial (uterus only removed)

Is the patient currently utilizing BHRT or HRT? ☐ Yes ☐ No

If yes, select types of Hormones: ☐ Testosterone ☐ Progesterone ☐ Estrogen ☐ Thyroid

List Name and Dose of Hormone(s): _____

Is the patient currently on statins? ☐ Yes ☐ No

Is the patient a smoker? ☐ Yes ☐ No

Is the patient currently on oral nitrates? ☐ Yes ☐ No

## MEDICAL HISTORY

**Select all that apply:**

Cardiovascular Conditions:

- ☐ Heart Attack or Stroke (within last 6 months)
- ☐ DVT or Blood Clot (within last 6 months)
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Obstructive Sleep Apnea
- ☐ Atrial Fibrillation
- ☐ Tachycardia

Gynecological Conditions:

- ☐ Pre-Menstrual Syndrome
- ☐ Endometriosis or History of Endometriosis
- ☐ Fibrocystic Breast Disease
- ☐ Fibroids or History of Fibroids
- ☐ Polyps or History of Endometrial Polyps

Cancer:

- ☐ Breast Cancer or History of Breast Cancer
- ☐ Endometrial Cancer
- ☐ Cervical Cancer
- ☐ Ovarian Cancer
- ☐ Thyroid Cancer or History of Thyroid Cancer
- ☐ Meningioma
- ☐ Except for Basal Cell Carcinoma any Other Cancers?

Neurological Conditions:

- ☐ Epilepsy or Seizure Disorder
- ☐ Depression/Anxiety

# BIOTE FEMALE HEALTH HISTORY & SYMPTOMS

## MEDICAL HISTORY

**Endocrine and Metabolic:**

- ☐ PCOS
- ☐ Diabetes Type 2 or Insulin Resistance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Multiple Endocrine Neoplasia Type-2

**Autoimmune Conditions:**

- ☐ Diabetes Type 1
- ☐ Hashimoto's Thyroiditis
- ☐ Graves' Disease
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus (Erthematosus)
- ☐ Psoriasis
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

**Organ Specific Conditions:**

- ☐ Liver Disease or History of Liver Disease
- ☐ Kidney Disease or History of Kidney Disease
- ☐ LAM (Lymphangioleimyomatosis)
- ☐ Osteoporosis or Osteopenia
- ☐ HIV
- ☐ Hepatitis
- ☐ Hemochromatosis
- ☐ Pancreatitis or History of Pancreatitis
- ☐ History of or Gall Bladder Disease

## SYMPTOMS AND CONCERNS

**Select all that apply:**

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Decreased Interest in Sex
- ☐ Inability To or Delayed Orgasm
- ☐ Painful Intercourse
- ☐ Urinary Incontinence
- ☐ Frequent Urinary Tract Infection
- ☐ Breast Tenderness
- ☐ Weight Gain
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Thinning Eyebrows
- ☐ Cold Hands or Feet
- ☐ Brittle Nails
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decreased Muscle Mass
- ☐ Acne
- ☐ Facial Hair
- ☐ Dry Eyes
- ☐ Joint Pain
- ☐ Difficulty Sleeping
- ☐ Mind Racing at Bedtime

## Mammogram Waiver for Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

**For today's appointment I DO NOT have a mammogram for the following reason:**
**( ) My decision not to have one.**
**( ) Unable to provide the report at this time.**
**( ) My doctor's decision not to have one.** *Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram.*

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol. _____(initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.
I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Today's Date |

ProHealth
PHYSICAL MEDICINE
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# Pap Smear Waiver for Estradiol Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio- identical testosterone and/or estradiol pellet therapy.

**( ) For today's appointment I DO NOT have a PAP Smear for the following reason:**

- **( ) My decision not to have one.**
- **( ) Unable to provide the report at this time.**
- **( ) My doctor's decision not to have one.** *Please provide a note from your treating physician with their rationale as to why they don't want you to have a PAP Smear.*

**( ) For today's appointment I DO NOT have a Transvaginal Ultrasound for the following reason:**

- **( ) My decision not to have one.**
- **( ) Unable to provide the report at this time.**
- **( ) My doctor's decision not to have one.** Please provide a note from your treating physician with their rationale as to why they don't want you to have a Transvaginal Ultrasound.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a Pap smear and/or Transvaginal Ultrasound since I receive testosterone and/or estradiol. _____(initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that PAP smear and/or Transvaginal Ultrasounds are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a Pap smear and/or Transvaginal Ultrasound may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer issues) that may be sustained by me in connection with my decision to not have a PAP Smear and/or Transvaginal Ultrasound and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

| Print Name | Signature | Today's Date |
|---|---|---|

# Commonly Asked Questions

**Q. What is BioTE®?**
A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance to youthful levels in men and women.

**Q. How do I know if I'm a candidate for pellets?**
A. Symptoms may vary widely from depression and anxiety to night sweats and sleeplessness for example. You will be given a lab slip to have blood work done which will determine your hormone levels. Once the doctor reviews and determines you are a candidate we will schedule an appointment for insertion.

**Q. Do I have blood work done before each Treatment?**
A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

**Q. What are the pellets made from?**
A. They are made from wild yams and soy. Wild yams and soy have the highest concentration of hormones of any substance. There are no known allergens associated with wild yams and soy, because once the hormone is made it is no longer yam or soy.

**Q. How long will the treatment last?**
A. Every 3-6 months depending on the person. Everyone is different so it depends on how you feel and what the doctor determines is right for you. If you are really active, you are under a lot of stress or it is extremely hot your treatment may not last as long. Absorption rate is based on cardiac output.

**Q. Is the therapy FDA approved?**
A. What the pellets are made of is FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and Respective State Pharmacy Boards. The PROCEDURE of placing pellets is NOT an FDA approved procedure. The pellets are derived from wild yams and soy, and are all natural and bio-identical. Meaning they are the exact replication of what the body makes.

**Q. How are they administered?**
A. Your practitioner will implant the pellets in the fat under the skin of the hip. A small incision is made in the hip. The pellets are inserted. No stitch is required.

**Q. Does it matter if I'm on birth control?**
A. No, the doctor can determine what your hormone needs are even if you are on birth control.

**Q. Are there any side effects?**
A. The majority of side effects is temporary and typically only happens on the first dose. All are very treatable. There are no serious side effects.

**Q. What if I'm already on HRT of some sort like creams, patches, pills?**
A. This is an easy transition. The doctor will be able to determine your needs even though you may be currently taking these other forms of HRT.

**Q. What if I've had breast cancer?**
A. Breast cancer survivors and/or those who have a history of breast cancer in their family may still be a candidate; however, this is to be determined by the physician. You should schedule a consultation with the Doctor.