

# 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 MALE HEALTH HISTORY & SYMPTOMS

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

## PATIENT QUESTIONS

Currently trying to conceive?  Yes  No

Desire to conceive in the future?  Yes  No

Is patient on a 5-alpha reductase inhibitor?  Yes  No

Is the patient on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)  Yes  No

Is the patient on any other testosterone boosting medication (Clomid, HCG, etc.)?  Yes  No

Is the patient currently utilizing BHRT or HRT?  Yes  No

If yes, select types of Hormones:  Testosterone  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:

#### Fertility:

Patient Wants to Maintain Fertility

#### Cardiovascular Conditions:

Heart Attack or Stroke (within last 6 months)

DVT or Blood Clot (within last 6 months)

Hypertension

Hyperlipidemia

Obstructive Sleep Apnea

Patient Takes Anticoagulant Medication

Atrial Fibrillation

Tachycardia

#### Cancer:

Breast Cancer

Active Prostate Cancer or History of Prostate Cancer

Thyroid Cancer or History of Thyroid Cancer

Meningioma

Polycythemia Vera (PV)

Except for Basal Cell Carcinoma any Other Cancers?

#### Neurological Conditions:

Epilepsy or Seizure Disorder

#### Endocrine and Metabolic:

Diabetes Type 2 or Insulin Resistance

Hyperthyroid

Hypothyroid

Multiple Endocrine Neoplasia Type-2

# BIOTE MALE HEALTH HISTORY & SYMPTOMS

## MEDICAL HISTORY

### Autoimmune Conditions:

- Diabetes Type 1
- Hashimoto's Thyroiditis
- Graves' Disease
- Rheumatoid Arthritis
- Multiple Sclerosis
- Systemic Lupus (Erythematosus)
- Psoriasis
- Positive ANA
- 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 (Lymphangiomyomatosis)
- Osteoporosis or Osteopenia
- Prostate Enlargement (BPH)
- HIV
- Hepatitis
- Hemochromatosis
- Pancreatitis or History of Pancreatitis
- History of or Gall Bladder Disease

## SYMPTOMS AND CONCERNS

### Select all that apply:

- Acne
- Erectile Dysfunction (ED)
- Decreased Libido
- Decreased Desire
- Inability To or Delayed Orgasm
- Weight Gain
- Decreased Muscle Mass
- Difficulty Sleeping
- Urinary Incontinence
- Dry or Flaking Skin
- Lack of Energy (Fatigue)
- Decrease in Strength or Endurance
- Decrease in Work Performance
- Frequent Urinary Tract Infection
- Brittle Nails
- Thinning Eyebrows
- Hair Thinning
- Cold Hands or Feet
- Mind Racing at Bedtime
- Mood Swings
- Gynecomastia
- Abdominal Obesity



## Prostate Exam Waiver for Testosterone Pellet Therapy

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

**For today's appointment, I have not provided you with a prostate exam report for the following reason:**

- My decision not to have a prostate exam.**
- I am unable to provide it at this time.**

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 prostate exam since I receive testosterone. \_\_\_\_\_ (initials of patient)

A prostate exam is the best single method for detection of early prostate cancer. I understand that my refusal to submit to a prostate exam may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of increase of such undetected cancer.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to undergo testosterone 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 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.

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Print Name

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Signature

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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.