bioTE®
MEDICAL

New Patient Information Sheet

Today's Date: _____

Name: _____ B-Day: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Gender: ____ Male ____ Female Height: _____ Weight: _____

Do you use tobacco? Yes __ No __ How often and how much? _____
Do you use alcohol? Yes __ No __ How often and how much? _____
Do you use caffeine? Yes __ No __ How often and how much? _____

Doctor's Name: _____

Address: _____

Phone: _____

Nutritional/Natural Supplements: Please Identify and list the products you are using:

_____

Medications/Hormone Supplements: _____

_____

Surgeries _____

_____

_____

Current Prescription Medications: _____

_____

Signature_____ Date:_____

bioTE MEDICAL

Name: _____ Today's Date: MM DD YYYY

LAST FIRST MIDDLE

Date of Birth: MM DD YYYY

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _____

LAST FIRST MIDDLE

Spouse's Date of Birth MM DD YYYY

Spouse's Employer: _____

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____

Contact Information: _____

HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: MM DD YYYY

What is the reason for your visit today? Please describe the symptoms & be specific:

_____

_____

_____

_____

How did you hear about us?: _____

_____

_____

bioTE MEDICAL

Prostate & Testicular History

Age of first intercourse experience: _____

Are you currently sexually active: ☐ YES ☐ NO

Have you had any sexually transmitted diseases (STDs): ☐ YES ☐ NO

Please list: _____

_____

Have you had a sperm count: ☐ YES ☐ NO

What were the results of the sperm count: _____

Have you had the mumps: ☐ YES ☐ NO

When did you have the mumps: _____

Have you ever had testicular cancer: ☐ YES ☐ NO

What type of treatment did you receive: _____

Do you have prostate problems: ☐ YES ☐ NO

Do you have or have you had prostatitis: ☐ YES ☐ NO

Is your prostate enlarged: ☐ YES ☐ NO

Have you ever had prostate cancer: ☐ YES ☐ NO

What type of treatment did you receive: _____

Have you had blood in your urine: ☐ YES ☐ NO

If yes, when did this occur: _____

Please describe treatment used: _____

_____

Do you have bladder or kidney issues: ☐ YES ☐ NO

If yes, please describe current treatment, if any: _____

_____

Do you have erectile dysfunction: ☐ YES ☐ NO

If yes, please describe: _____

_____

Are you suffering from the following (please check all that apply)

Fatigue: ☐ YES ☐ NO

Decrease of memory: ☐ YES ☐ NO

Decrease in energy level: ☐ YES ☐ NO

Decrease in sexual desire: ☐ YES ☐ NO

Are you suffering from the following (please check all that apply)

Anxiety:	☐ YES	☐ NO
Irritability:	☐ YES	☐ NO
Mood swings:	☐ YES	☐ NO
Migraines:	☐ YES	☐ NO
Memory loss:	☐ YES	☐ NO
Foggy thinking:	☐ YES	☐ NO
Muscle loss:	☐ YES	☐ NO
Poor response to exercise:	☐ YES	☐ NO
Poor recovery from exercise:	☐ YES	☐ NO

Please describe the way in which these issues have been dealt with:

_____

_____

_____

_____

Do you initiate intercourse:	☐ YES	☐ NO
Is intercourse satisfying:	☐ YES	☐ NO
Do you achieve orgasm:	☐ YES	☐ NO
Do you suffer from premature ejaculation:	☐ YES	☐ NO
How often do you have intercourse:	☐ YES	☐ NO
Is your sex drive similar as it was five years ago:	☐ YES	☐ NO

Please describe:

_____

_____

List any other sexual dysfunctions:

_____

_____

Have you experienced weight gain in the last 1-2 years:	☐ YES	☐ NO

If yes, please describe: _____

_____

_____

Have you lost more than 10 pounds in less than a month:	☐ YES	☐ NO

If yes, why:

Have you ever been tested for HIV/AIDS: ☐ YES ☐ NO

Are you HIV positive: ☐ YES ☐ NO

If yes, when did this occur: _____

Please describe:

Have you fathered any children: ☐ YES ☐ NO

If yes, how many: _____

Have you ever had your testosterone level taken in the past: ☐ YES ☐ NO

If yes, why: _____

Please check the box that best describes your sexual orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual

List all current medications and dosage amount:

MEDICAL HISTORY

Do you have **diabetes**: ☐ YES ☐ NO

Do you have or have you ever had **hypertension**: ☐ YES ☐ NO

Do you have **heart disease**: ☐ YES ☐ NO

Have you ever had a heart attack or stroke: ☐ YES ☐ NO

Have you ever had lung cancer: ☐ YES ☐ NO

If yes, please describe treatment used: _____

Have you ever had colon polyps: ☐ YES ☐ NO

If yes, please describe treatment used: _____

Have you ever had stomach/intestinal cancer: ☐ YES ☐ NO

If yes, what type: _____

Please describe treatment used: _____

Have you ever had leukemia or lymphoma: ☐ YES ☐ NO

If yes, what type: _____

Please describe treatment used: _____

Do you have a **heart murmur**: ☐ YES ☐ NO

Do you have or have you ever had **kidney disease**: ☐ YES ☐ NO

Have you ever been treated for a **psychiatric disorder**: ☐ YES ☐ NO

If yes, please name the disorder:

Have you ever had **rheumatic fever**: ☐ YES ☐ NO

Do you have **mitral valve prolapse**: ☐ YES ☐ NO

Have you ever had a **urinary tract infection**: ☐ YES ☐ NO

Have you ever had **hepatitis**: ☐ YES ☐ NO

If yes, please check which type:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had **liver disease**: ☐ YES ☐ NO

Have you ever had **varicose veins**: ☐ YES ☐ NO

Have you ever had **phlebitis**: ☐ YES ☐ NO

Do you have any **thyroid problems**: ☐ YES ☐ NO

If yes, please check the problem:

☐ Low Function ☐ Overactive ☐ Goiter ☐ Hashimoto

Have you ever had a **blood transfusion**: ☐ YES ☐ NO

Do you have a **lung disease**: ☐ YES ☐ NO

Do you have **asthma, emphysema** or **chronic bronchitis**: ☐ YES ☐ NO

Do you have **lupus, scleroderma, collagen disease**: ☐ YES ☐ NO

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Have you had any **major accidents**: ☐ YES ☐ NO

Do you have any **drug allergies**: ☐ YES ☐ NO

If yes, please list the drugs you are allergic to: _____

Have you ever had any problems with your blood ☐ YES ☐ NO

If yes, please list the blood problems (such as anemia and excess blood cells: _____

_____

Have you ever had multiple myeloma: ☐ YES ☐ NO

Please describe treatment used: _____

_____

Please list all operations/hospitalizations (including year and reason):

_____

_____

_____

_____

Have you ever had any anesthesia complications: ☐ YES ☐ NO

If yes, please explain: _____

_____

Do you have an Internist or Family Physician: ☐ YES ☐ NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____

Are you currently taking any medications: ☐ YES ☐ NO

Please list the medications your are currently taking and the dosage amount:

_____

_____

Have you ever had your cholesterol checked: ☐ YES ☐ NO

If yes, what was the date it was last checked: _____

How was your cholesterol: ☐ Low ☐ Normal ☐ High

SOCIAL HISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please try list the number you smoke per day on average: _____

Please list the number of years you have been smoking: _____

Do you use recreational drugs: ☐ YES ☐ NO

Do you drink alcohol: ☐ YES ☐ NO

If yes, what type of alcohol do you drink: _____

How many drinks **per week** , on average, do you drink: _____

Are you using any form of Testosterone or Hormone Therapy: ☐ YES ☐ NO

If yes, please check which type:

☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

Use by Permission, ©2009 SottoPelle®. Copyright claimed in all other content.

bioTE®
MEDICAL

DATE:_____

NAME _____ WT _____B/P_____Temp_____
CURRENT MEDICATIONS:

SURGERY/HISTORY:

SYMPTOMS:

LABS

Estradiol _____Testosterone_____ Free Test _____PSA _____Vit D_____

TSH _____Free T3_____ CBC_____Chem Panel_____

PLAN

1) TREAT WITH: TEST _____ MG
2) Femara:_____Vitamin D:_____

Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Hormone pellets are made from soy and hormone replacement using pellets has been used in Europe, the US and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone with pellets.

Risks of not receiving testosterone therapy after andropause include but are not limited to:

Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **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. Lack of effect (typically from lack of absorption). Thinning hair, male pattern baldness. Increased growth of prostate and prostate tumors. Extrusion of pellets. Hyper sexuality (overactive Libido). Ten to fifteen percent shrinkage in testicle size. There can also be a significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a rectal exam and prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. 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 (secondary to hormonal decline). Decreased weight (Increase in lean body mass). 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 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 _____

Prostate Exam Waiver
for Testosterone Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous
(Patient Name)

bio-identical Estradiol & Testosterone pellet therapy with _____.
(Treating Provider)

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

☐ My decision not to have a prostate exam.

☐ I am unable to provide it at this time.

Prostate Exam report information:

Date of Prostate Exam report: _____

My results were: ☐ Normal ☐ Abnormal

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 refrain from obtaining a prostate exam. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless Dr. Tutera, Treating Physician, SottoPelle, Inc., and any of their SottoPelle® 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 my refusal to undergo a prostate exam. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date