

Female New Patient Package

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

2 weeks or more before your scheduled consultation: Get your blood lab drawn at any Quest Laboratory/ or LabCorp Lab. If you are not insured or have a high deductible, call our office for self-pay blood draws. We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to two weeks for your lab results to be received by our office.**

Your blood work panel MUST include the following tests:

- Estradiol
- FSH
- Testosterone Total
- TSH
- T4, Total
- T3, Free
- T.P.O. Thyroid Peroxidase
- CBC
- Complete Metabolic Panel
- Vitamin D, 25-Hydroxy (Optional)
- Vitamin B12 (Optional)
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

- FSH
- Testosterone Total
- CBC
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
- TSH, T4 Total, T3 Free, TPO **(Needed only if you've been prescribed thyroid medication)**
- Estradiol

Lone Star Surgery

Sulphur Springs 903-885-2820

Rockwall 972-961-4300

Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

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

Home Address: _____ City: _____ State: _____

SS#: _____ Insurance: _____ Pharmacy: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? () YES () NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

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

In the event we cannot contact you by the mean's you've 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 with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

How did you hear about us: _____

Social:

- () I am sexually active.
- () I want to be sexually active.
- () I have completed my family.
- My sex has suffered.
- () I haven't been able to have an orgasm.

Habits:

- () I smoke cigarettes or cigars _____ per day.
- () I drink alcoholic beverages _____ per week.
- () I drink more than 10 alcoholic beverages a week.
- () I use caffeine _____ a day.

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- () Medical/GYN Exam in the last year.
- () Mammogram in the last 12 months.
- () 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.
- () Hysterectomy with removal of ovaries.
- () Hysterectomy only.
- () Oophorectomy Removal of Ovaries.

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: _____

BHRT Checklist For Women

Name: _____

Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive/libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to climax sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry and Wrinkled Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair is Falling Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling all over the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History

	NO	YES
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Hormone Replacement Fee Acknowledgment

You will be responsible for payment in full at the time of your procedure.

Female Hormone Pellet Insertion Fee	\$325
Male Hormone Pellet Insertion Fee	\$625
Male Pellet Insertion Fee ($\geq 2000\text{mg}$)	\$725

We accept the following forms of payment:

Master Card, Visa, American Express, Personal Check, Discover, and Cash.

Print Name

Signature

Today's Date