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.

We look forward to partnering with you to help you feel your best again.

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 FASTING 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. Please fast for 12 hours prior to your blood draw.

Your fasting 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 Total, TPO (Needed only if you’ve been prescribe thyroid medication)
Female Patient Questionnaire & History

Name: ___________________________________________________________ Today’s Date: ____________

( Last)   (First)   (Middle)

Date of Birth: ______________ Age: ________ Occupation: ____________________________________________

Home Address: __________________________________________________________________________________

City: ___________________________________________________ State: __________ Zip: _______________

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: ____________________

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

<table>
<thead>
<tr>
<th>Symptom (please check mark)</th>
<th>Never</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Depressive mood</td>
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<tr>
<td>Memory Loss</td>
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<tr>
<td>Mental confusion</td>
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<tr>
<td>Decreased sex drive/libido</td>
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<td>Sleep problems</td>
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<tr>
<td>Mood changes/Irritability</td>
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<tr>
<td>Tension</td>
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<tr>
<td>Migraine/severe headaches</td>
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<tr>
<td>Difficult to climax sexually</td>
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<tr>
<td>Bloating</td>
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<tr>
<td>Weight gain</td>
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<tr>
<td>Breast tenderness</td>
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<tr>
<td>Vaginal dryness</td>
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<tr>
<td>Hot flashes</td>
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<tr>
<td>Night sweats</td>
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<tr>
<td>Dry and Wrinkled Skin</td>
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<tr>
<td>Hair is Falling Out</td>
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<tr>
<td>Cold all the time</td>
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<tr>
<td>Swelling all over the body</td>
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<tr>
<td>Joint pain</td>
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</tbody>
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Other symptoms that concern you:

__________________________
__________________________
__________________________
Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are made from yam and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone cannot be given to pregnant women.

**My birth control method is:** (please circle)
- Abstinence
- Birth control pill
- Hysterectomy
- IUD
- Menopause
- Tubal ligation
- Vasectomy
- Other

**CONSENT FOR TREATMENT:** I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure.**

**Side effects may include:** Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); safety of any of these hormones 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 genital ambiguity; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. 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 and 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. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer’s and dementia.

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 bio-identical 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 bio-identical therapy. 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 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.
Hormone Replacement Fee Acknowledgment

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN’s or NP’s, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (aesthetic medicine) and therefore is not covered by health insurance in most cases.

This practice is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

New Patient Consult Fee ................................................................. $125.00

Female Hormone Pellet Insertion Fee............................................. $350.00

We accept the following forms of payment:

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

Print Name  Signature  Today’s Date
OFFICE USE ONLY FEMALE INTAKE FORM

NAME: ___________________________________________ DATE: ______________

Height: ________ Weight: ________ Blood Pressure: ________ Temperature: ________

CURRENT MEDICATIONS: __________________________________________________________________________

SURGERY/ HISTORY: Hysterectomy: (   ) YES (   ) NO Ovaries: (   ) YES (   ) NO

Last Pap: _______________ Last Mammogram: _______________ Normal: (   ) YES (   ) NO

________________________________________________________________________________________________

SYMPTOMS: __________________________________________________________________________________________

________________________________________________________________________________________________

LABS: Estradiol: ________ Testosterone: ________ FSH: ________ Vitamin D: ________ Vitamin B12: ________


LDL: ________ HDL: ________ Triglycerides: ________

PLAN:

This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Betadine swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri - strips and/or Foam Tape were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient. Pellets used are as follows:

TREAT WITH:

1. Testosterone: ________ MG’s Testosterone Lot Numbers: __________________________
2. Estradiol: ________ MG’s Estradiol Lot Numbers: __________________________
3. Progesterone: __________________________ CYCLE or CONTINUOUS (circle one)
5. Vitamin ADK: ________ Thyroid: ________ Iodine: ________
6. Evening Primrose: __________________________
7. Other: __________________________________________

COMMENTS: _______________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

OFFICE USE ONLY FEMALE PATIENT TREATMENT FORM
NAME: _______________________________________________

DATE ______________

SYMPTOMS/NOTES:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

PROCEDURE REPORT:

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Weight ________ Estradiol __________ mg  Testosterone __________ mg

Insertion site: Left Hip ( ) Right Hip ( )

DATE ______________

SYMPTOMS/NOTES:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

PROCEDURE REPORT:

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Insertion site: Left Hip ( ) Right Hip ( )