



A Division of Visionary Centre for Women

Male 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 Lab, BayCare Lab or LabCorp Lab. **IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, SEE BELOW FOR OUR OFFICE 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 blood work panel MUST include the following tests:

- Estradiol
- Testosterone Free & Total
- PSA Total
- TSH
- T4, Total
- T3, Free
- T.P.O. Thyroid Peroxidase

We can also draw your blood in our office and send it to your lab of choice using your insurance.

**SELF PAY BLOOD DRAWS in our office: Pre-pellet: \$150
Post-pellet: \$50**

- CBC
- Complete Metabolic Panel
- Vitamin D, 25-Hydroxy
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Male Post Insertion Labs Needed at 4 Weeks:

- Estradiol
- Testosterone Free & Total
- PSA Total (If PSA was borderline on first insertion)
- CBC
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
- TSH, T4 Total, T3 Free, TPO **(Only needed if you've been prescribed thyroid medication)**



Male Patient Questionnaire & History

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

Date of Birth: _____ Age: _____ Ht: _____ Weight: _____ 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: _____

Preferred Phone Contact: _____ May we text you? () YES () NO

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 means 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.

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

- () I am sexually active.
- () I want to be sexually active.
- () I have completed my family.
- () I have used steroids in the past for athletic purposes.

Habits:

- () I smoke cigarettes or cigars _____ a 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: _____

Other Pertinent Information: _____

Medical Illnesses:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure. | <input type="checkbox"/> Testicular or prostate cancer. |
| <input type="checkbox"/> High cholesterol. | <input type="checkbox"/> Elevated PSA. |
| <input type="checkbox"/> Heart Disease. | <input type="checkbox"/> Prostate enlargement. |
| <input type="checkbox"/> Stroke and/or heart attack. | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart. |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli. | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis). |
| <input type="checkbox"/> Hemochromatosis. | <input type="checkbox"/> Diabetes. |
| <input type="checkbox"/> Depression/anxiety. | <input type="checkbox"/> Thyroid disease. |
| <input type="checkbox"/> Psychiatric Disorder. | <input type="checkbox"/> Arthritis. |
| <input type="checkbox"/> Cancer (type): _____ | |
| Year: _____ | |

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name

Signature

Today's Date

Name: _____ Date of birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep or falls asleep easily after a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire or in sexual performance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile changes (weaker erections, loss of morning erections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss or thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or absent ejaculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	_____				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80



Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	\$285.00
Male Hormone Pellet Insertion Fee	\$700.00
Male Hormone Pellet Insertion Fee (>2000mg)	\$800.00

We accept the following forms of payment:

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

Print Name

Signature

Today's Date