Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

# Male Patient Questionnaire & History

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

Date of Birth: _____ Age: _____ Ht: _____'_____" Wt: _____Occupation: _____

Home Address: _____City: _____ State: _____ Zip: _____

Social Security #:_____Home Phone: _____ Cell Phone: _____

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

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Pharmacy Name and Address: _____Pharmacy Ph: _____

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

**( ) I give OHHA permission to contact the following individuals to discuss any portion of my treatment plan (please include spouse or significant other)**

Name: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____Cell Phone: _____

**Social:**
( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletics.

**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.

How did you hear about us?_____

**Family History - List chronic illnesses for family members listed below:**
(Ex. High Blood Pressure, High Cholesterol, Diabetes, Cancer, etc.)

**Mother:** _____

**Father :** _____

**Siblings :** _____

Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

# Medical History

Any known drug allergies: _____

**Medications Currently Taking (including vitamins and nutritional supplements):**

| **Name of Medication/Supp.** | **Dose & Frequency** | **Reason taking** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Surgeries, list all and dates: _____

Have you ever had any issues with anesthesia? ( )Yes ( )No If yes, please explain: _____

Other Pertinent Information: _____

## Personal Medical History

**Preventative Medical Care:**

| | | **Normal/Abnormal** |
|---|---|---|
| ( ) Annual Physical | Date: _____ | _____ |
| ( ) Prostate Check | Date: _____ | _____ |
| ( ) Cardiac Physical | Date: _____ | _____ |
| ( ) Colonoscopy | Date: _____ | _____ |

**Medical Illnesses:**

| | |
|---|---|
| ( ) High Blood Pressure | |
| ( ) High Cholesterol | |
| ( ) Heart Disease | |
| ( ) Stroke and/or Heart Attack. | Date: _____ |
| ( ) Blood Clot and/or a Pulmonary Emboli | Date: _____ |
| ( ) Hemochromatosis | |

**Medical Illnesses Cont'd:**

- ( ) Any Form of Hepatitis or HIV
- ( ) Depression/Anxiety
- ( ) Psychiatric Disorder
- ( ) Cancer (type): _____Year_____
- ( ) Testicular or Prostate Cancer Date: _____
- ( ) Elevated PSA
- ( ) Prostate Enlargement
- ( ) Trouble Passing Urine or Take Flomax or Avodart
- ( ) Chronic Liver Disease (hepatitis, fatty liver, cirrhosis)
- ( ) Diabetes
- ( ) Thyroid disease
- ( ) Arthritis

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**

Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

## BHRT CHECKLIST FOR MEN

**Name:** _____ **Date:** _____

**E-Mail:** _____

| Symptom *(please check mark)* | Never | Mild | Moderate | Severe |
|---|---|---|---|---|
| Decline in general well being | | | | |
| Joint pain/muscle ache | | | | |
| Excessive sweating | | | | |
| Sleep problems | | | | |
| Increased need for sleep | | | | |
| Fatigue | | | | |
| Irritability | | | | |
| Nervousness | | | | |
| Anxiety | | | | |
| Depressed mood | | | | |
| Exhaustion/lacking vitality | | | | |
| Declining Mental Ability/Focus/Concentration | | | | |
| Feeling you have passed your peak | | | | |
| Feeling burned out/hit rock bottom | | | | |
| Decreased muscle strength | | | | |
| Weight Gain/Belly Fat/Inability to Lose Weight | | | | |
| Breast Development | | | | |
| Shrinking Testicles | | | | |
| Rapid Hair Loss | | | | |
| Decrease in beard growth | | | | |
| New Migraine Headaches | | | | |
| Decreased desire/libido | | | | |
| Decreased morning erections | | | | |
| Decreased ability to perform sexually | | | | |
| Infrequent or Absent Ejaculations | | | | |
| No Results from E.D. Medications | | | | |

**Other symptoms that concern you:**

| |
|---|
| |
| |
| |

Optimal Hormone Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

# Office Policies and Procedures for Patients

**(Please initial in the spaces provided and sign the bottom)**

**Office Hours:**

_____ Office hours for Optimal Hormone Health & Aesthetics (OHHA) are as follows: Monday – Friday: 9:00 a.m. – 5:00 p.m. (closed daily from noon -1:30) If you need an appointment or prescription refill, please call during regular business hours.

**Appointments:**

_____To ensure timely service and medical care, we encourage you to schedule your appointment in advance. If you must cancel your appointment, please give our office 24-hour advanced notice. This gives us an opportunity to reallocate time for another patient. If you are unable to provide a 24-hour notice of cancellation, **you will be charged $50**, to be paid at your next appointment.

**Late Arrivals:**

_____It is our goal to provide quality time and care to each patient. While we understand there may be some things out of your control, we encourage you to be **ON TIME** for appointments. Late arrivals may interfere with another patient's care. We will do our best to accommodate you if you are running late but depending on scheduling, it may be necessary to reschedule.

**No Show:**

_____A "no show" is someone who misses an appointment without calling or fails to give 24-hours' notice. Three (3) "no shows" within one calendar year may result in loss of service. You will also be billed **a "no show" fee in the amount of $50**, to be paid at the time of your next visit.

**Prescription Refills and Pharmacy Information:**

_____Please do not wait until the last minute for refill requests. Please, plan ahead and allow 2 full business days to complete refill requests. Refill requests must be done during normal business hours. We do not have access to your patient record after hours, therefore, no medications will be refilled after hours or on weekends. If your prescription is lost, expired, or must be replaced, a replacement must be picked up at the office. There will be a **$25 fee for replaced prescriptions.** Please review your medications prior to appointments and request refills at the time of visit, if needed. Every patient will be given enough medication to last until the next recommended office visit and/or lab draw.

**Insurance Disclaimer:**

_____OHHA is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, office visits, or pellets). We will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. The form and the receipt are your responsibility. WE WILL NOT, communicate in any way with insurance companies regarding your benefits.

**HIPAA Information and Consent Form:**

_____I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM, a copy of which has been provided to me by OHHA, and any subsequent changes in office policy. I understand that this consent shall remain in force from this date forward.

**Medical Records:**

_____To ensure your privacy, copies of medical records must be requested in writing per HIPPA guidelines and a medical release form must be completed in advance. Medical records can be faxed or mailed to other clinicians but cannot be emailed due to confidentiality concerns. The law allows medical offices 30 days to complete requests for records. It is our goal to respond to your request in a timely manner. **There is a $25 fee to copy medical records for patients. The request for records to be sent to another clinician is free.**

**Forms and Letters:**

_____OHHA will assist in the completion of certain forms and letters as follows: 1) Letters of Necessity, 2) Prior Authorizations for prescriptions only, and 3) Employment Physical forms. Please allow 7-10 days for completion of requested forms/letters. There will be a $**25 charge for the completion of short forms** and letters and a **$45 charge for more extensive forms/letters.**

**Right to terminate:**

_____OHHA reserves the right to terminate services due to failure to comply with policies and procedures. OHHA reserves the right to terminate services due to inappropriate and/or threatening behaviors and/or comments made to clinicians and/or staff.

**OHHA Pricing:**

_____I have reviewed and understand OHHA's price policy and further understand that **payment is due upon receipt of services rendered**. I understand that I may request a copy of OHHA's price list at any time and it will gladly be provided to me.

**Printed name:**_____**Signature:**_____**Date:**_____

Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

# 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. Pellets have 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.

**Patient Signature** _____ **Today's Date** _____

Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

## Post-Insertion Instructions for Men

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. You may replace it with a bandage to catch any anesthetic that may ooze out. The inner layer is either waterproof foam tape or steri-strips they should not be removed before 7 days.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for 3 days. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next 7 days, this includes running, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days. Don't worry, this is normal.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding (not oozing) or pus coming out of the insertion site that is not relieved by pressure.
- Remember to go for your post-insertion blood work 4 weeks after the insertion.
- Most men will need re-insertions of their pellets 5-6 months after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. Or you may make your next appointment before you leave today. The charge for the second visit will be only for the insertion and not a consultation unless you would like to discuss treatment and additional hormonal health matters.

**Reminders:**

**Please have your labs rechecked:**

( ) 4-6 weeks after your insertion

( ) every 6 months

( ) every 12 months

**Prescriptions:**

| | |
|---|---|
| ( ) DIM _____ | Every _____ |
| ( ) Femara _____ | Every _____ |
| ( ) Vitamin ADK_____ | Every _____ |
| ( ) Iodine _____ | Every _____ |
| ( ) Thyroid _____ | Every _____ |
| ( ) Other _____ | Every _____ |
| ( ) Other _____ | Every _____ |
| ( ) Other _____ | Every _____ |

_____ _____

**Patient Signature** **Today's Date**

Optimal Hormone Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

## WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- **SWELLING of the HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

- **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.

- **FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents, and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

- **HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

- **HAIR GROWTH**: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Dosage adjustment generally reduces or eliminates the problem.

_____ _____

**Patient Signature** **Today's Date**

Optimal Hormone
Health & Aesthetics

5061 FM 2920
Spring, TX 77388
(281) 465-9209
(281) 651-4875 Fax

# Covid-19 Prescreen Information

**Patient Name:**_____

**Date:**_____

**DOB:**_____

1. Have you had any of the following symptoms within the last two weeks?

| | |
|---|---|
| Cough | _____Yes _____No |
| Congestion | _____Yes _____No |
| Shortness of breath | _____Yes _____No |
| Fever | _____Yes _____No |
| Loss of taste | _____Yes _____No |
| Loss of smell | _____Yes _____No |

2. Have you been around anyone who has had any of the above-mentioned symptoms within the last two weeks?
_____Yes _____No

3. Have you had a Covid-19 Test within the last two weeks?
_____Yes _____No If yes, date_____ Positive or Negative? (circle one)