Dear Patient:

You've made the right choice towards getting your life back on track. Pellets are a superior and remarkable method of Bio-Identical Hormone Replacement Therapy (BHRT). This type of therapy has been documented and researched in medical journals since 1939. Not only will you regain the energy, libido and vitality of your youth; we are here to help you get back to your normal physiological state of well-being. Won't that be a welcome relief?

Inside your packet, we've enclosed pages for you to fill out and pages with information.

Lab work: Please go to the lab within the next few days to ensure that your lab results are available by your scheduled appointment date. Please check with your insurance carrier prior to receiving your lab work to find out if your insurance covers the lab work.

THIS IS A FASTING LAB TEST: please fast for 8-10 hours before your lab work.

Please complete all the enclosed new patient forms and email to info@esprithealthclinic.com

or fax to 844-766-1639.

*** Please notify us 48 hours in advance of an appointment cancellation. ***

We are committed to making sure your treatment and visits with us are as positive as then can be. We understand you are a unique individual and we strive to provide you with the highest quality medical care. Our primary concern is to restore you to a state of well-being and optimum health. Our patients are treated with compassion and respect. We encourage you to openly express your needs and concerns to our staff.

We look forward to seeing you soon.

Here's to your well-being!

FEMALE PATIENT INFORMATION

Name: _____ Today's Date: _____
LAST FIRST MIDDLE

Date of Birth: _____

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 _____

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: _____

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

How did you hear about us:

SYMPTOM CHECKLIST

Please indicate how often you have the following

Night sweats:	☐ Frequently	☐ Rarely	☐ Never
Hot flashes/hot flushes:	☐ Frequently	☐ Rarely	☐ Never
Pain with intercourse:	☐ Frequently	☐ Rarely	☐ Never
Vaginal dryness:	☐ Frequently	☐ Rarely	☐ Never
Sleeping problems:	☐ Frequently	☐ Rarely	☐ Never
Urine leaks when you cough or sneeze:	☐ Frequently	☐ Rarely	☐ Never
Decrease in physical sensation during intercourse	☐ Frequently	☐ Rarely	☐ Never
Feel air flowing from your vagina	☐ Frequently	☐ Rarely	☐ Never
Tampons feel like they are slipping out	☐ Frequently	☐ Rarely	☐ Never
Difficulty concentrating/memory loss:	☐ Frequently	☐ Rarely	☐ Never
Mood swings:	☐ Frequently	☐ Rarely	☐ Never
Migraines:	☐ Frequently	☐ Rarely	☐ Never
Depression:	☐ Frequently	☐ Rarely	☐ Never
Anxiety:	☐ Frequently	☐ Rarely	☐ Never
Decrease in sexual desire:	☐ Frequently	☐ Rarely	☐ Never
Decrease in energy level:	☐ Frequently	☐ Rarely	☐ Never
Loss of memory:	☐ Frequently	☐ Rarely	☐ Never
Foggy thinking:	☐ Frequently	☐ Rarely	☐ Never
Muscle and/or joint pain:	☐ Frequently	☐ Rarely	☐ Never

Please check the boxes below if they apply to how you have dealt with the above symptoms

Herbal medications/supplements	☐ YES	☐ NO
Please specify how: _____		
Change of diet:	☐ YES	☐ NO
Please specify how: _____		
Layered clothing:	☐ YES	☐ NO
Please specify how: _____		
Increase exercise:	☐ YES	☐ NO
Please specify how: _____		

Other: _____

_____

_____

GYN HISTORY

Are you sexually active: ☐ YES ☐ NO

Have you been sexually active: ☐ YES ☐ NO

Do you have pain with intercourse: ☐ YES ☐ NO

What type of contraception are you currently using (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

What type of contraception have you used in the past (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

Are you having any problems with your method of birth control: ☐ YES ☐ NO

Have you ever had any vaginal, cervical and/or tubal infection: ☐ YES ☐ NO

If yes, please check below call that apply:

☐ Gardnerella ☐ Syphilis ☐ Condyloma ☐ Bacterial Vaginitis

☐ Yeast ☐ PID ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Warts

☐ Other: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear ☐ YES ☐ NO

If yes, how was it treated (please check below all that apply):

☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy

☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Excition

Have you ever had cervical cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had uterine cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had ovarian cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have trouble leaking urine: ☐ YES ☐ NO

Do you have any breast lumps, tenderness or discharge: ☐ YES ☐ NO

Have you ever had a mammogram: ☐ YES ☐ NO

If yes, was it normal: ☐ YES ☐ NO

Date of last mammogram: _____

Do you do self breast exams: ☐ YES ☐ NO

Do you have PMS symptoms: ☐ YES ☐ NO

If yes, are you currently undergoing treatment: ☐ YES ☐ NO

If yes, what type of treatment: _____

Do you have any uterine abnormality: ☐ YES ☐ NO

Do you have a history of infertility: ☐ YES ☐ NO

Do you have a history of DES exposure ☐ YES ☐ NO

Do you have fibroids of the uterus: ☐ YES ☐ NO

Have you had abnormal bleeding in the past year: ☐ YES ☐ NO

If yes, please describe: _____

At what age did you start menopause: _____

MENSTRUAL HISTORY

If you no longer have periods, please check reason

☐ Natural ☐ Hysterectomy ☐ Ablation ☐ Menopause

Do you have a uterus: ☐ YES ☐ NO

First day of last period: _____

Typically, how many days do your periods last: _____

Are your periods regular: ☐ YES ☐ NO

How many days are between the start of your periods: _____

Has the flow of your period changed in any way: ☐ YES ☐ NO

If yes, please explain the change: _____

Does bleeding occur between your normal period cycle: ☐ YES ☐ NO

Do you suffer from cramps during your periods: ☐ YES ☐ NO

If yes, please check the pain associated with the cramps:

☐ MILD ☐ MODERATE ☐ SEVERE

What medicine, if any, are you currently taking for your cramps: _____

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

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**: ☐ YES ☐ NO

Have you ever had a **stroke**: ☐ YES ☐ NO

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's

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

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

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

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

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

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **colon cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **colon polyps**: If ☐ YES ☐ NO

yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **multiple myeloma**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **lung cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Do you have or have you ever had **rectal cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment: ☐ Surgery ☐ Radiation

Do you have or have you ever had **breast cancer**: ☐ YES ☐ NO

If yes, are you currently undergoing any treatment: ☐ YES ☐ NO

Please check the type of treatment

☐ Lumpectomy ☐ Mastectomy ☐ Radiation Therapy ☐ Chemotherapy

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

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

_____

Please list **all** major surgeries (including year and reason):

_____

_____

_____

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

_____

_____

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

If yes, please explain:

_____

Are you currently or have you ever been **anemic**: ☐ YES ☐ NO

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

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Do you have **lupus**: ☐ YES ☐ NO

Do you have **scleroderma**: ☐ YES ☐ NO

Do you have **rheumatoid arthritis**: ☐ YES ☐ NO

Have you had **blood clots in your legs or lungs**: ☐ YES ☐ NO

Do you have problems with **water retention**: Do ☐ YES ☐ NO

you have problems with **swelling**: ☐ YES ☐ NO

Do you have problems with **bloating**: ☐ YES ☐ NO

Do you have **osteopenia**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have **osteoporosis**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you suffer from **hair loss**: ☐ YES ☐ NO

Do you suffer from or have you had **acne**: ☐ YES ☐ NO

FAMILY HISTORY

Do you have a family history of **breast cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **colon cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **ovarian cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **osteoporosis**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **diabetes**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **hypertension**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **heart disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **kidney disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

At what age did your mother go though menopause: _____

Symptom Questionnaire

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0= you never experience the symptom
5= you experience the symptom severely and all the time

Dermatological

Dry Skin	__/5
Course Skin	__/5
Itchy Skin	__/5
Dry, course hair	__/5
Thinning/loss of hair	__/5
Thinning eyebrows	__/5
Brittle or ridges on nails	__/5
Excess wax in ears	__/5
Decreased sweat	__/5
Paleness of skin or lips	__/5
TOTAL	**__/50**

Metabolism

Lethargy (low energy)	__/5
Sensation of cold	__/5
Heat intolerance (not hot flashes)	__/5
Slow speech (non memory)	__/5
Weight gain with little food intake	__/5
Lack of appetite	__/5
Lack of libido	__/5
TOTAL	**__/30**

Dryness(sicca)

Dry eyes	__/5
Dry skin	__/5
Dry mouth	__/5
Dry nose	__/5
Dry sinuses	__/5
Dry vagina	__/5
TOTAL	**__/30**

Gastrointestinal

Constipation	__/5
Diarrhea	__/5
Irritable bowel syndrome	__/5
GERD (reflux disease)	__/5
TOTAL	**__/20**

Reproductive

Delayed menstrual flow	__/5
Excessive menstrual flow	__/5
Painful menses	__/5
Impotence (men only)	__/5
TOTAL	**__/20**

Mental/Emotional Well-being

Depression	__/5
Irritability/mood swings	__/5
Nervousness	__/5
Anxiety	__/5
Impaired memory	__/5
Impaired focus	__/5
TOTAL	**__/30**

Cardiovascular/Respiratory

Chest pain	__/5
Palpitations	__/5
Atrial fibrillation	__/5
Chronic cough of *unknown reason*	__/5
Airflow obstruction (non smokers)	__/5
Shortness of breath on physical exertion	__/5
Shortness of breath in general	__/5
TOTAL	**__/30**

Swelling

Swollen ankles	__/5
Swollen wrists	__/5
Swollen eyelids	__/5
Swollen, thick tongue	__/5
Swollen face	__/5
TOTAL	**__/25**

Musculoskeletal

Muscle weakness	__/5
Unexplained tingling or Numbness	__/5
Body aches	__/5
Muscle pain	__/5
Joint pain	__/5
Carpal tunnel syndrome	__/5
Plantar fasciitis	__/5
TOTAL	**__/35**

Sleep

Difficulty getting to sleep	__/5
Difficulty staying asleep	__/5
Wake unrefreshed	__/5
Sleep apnea	__/5
Snoring	__/5
TOTAL	**__/25**

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
__Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
__Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
__Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)

Female Hormone Symptom Diary

Name: _____

SYMPTOMS: Rate 1-10 (10 is the worst)	Before Treatment Date:	Month #1 Date:	Month #2 Date:	Month #3 Date:	Month #4 Date:	Month #5 Date:	Month #6 Date:
Fatigue							
Insomnia							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Depression							
Anxiety							
Muscle Weakness							
Migraine Headaches							
Hair Loss							
Dry Skin							
Facial Hair							
Nausea							
Muscle Pain							
Joint Pain							
Foggy Mind							
Loss of Well Being							
Poor Results from Exercise							
Painful Intercourse							
Vaginal Dryness							
Night Sweats							
Hot Flashes							

Informed Consent for Female Estradiol & Testosterone Hormone Insertion

This consent form provides written confirmation that a discussion regarding bio-identical hormone insertion has occurred, and I agree to proceed.

General Bio-identical hormone pellets are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone, which are made in the ovaries and adrenal glands. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Birth Control Patients who are pre-menopausal **must** continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is listed as category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is:

____Abstinence	____Hysterectomy	____Menopause	____Other:
____Birth control pill	____IUD	____Tubal Ligation	_____

Benefits I consent to having testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. The potential benefits of testosterone include a possible increase in my bone density, short term memory, protection against Alzheimer's, increase in my energy, my libido, and my sense of well-being. Testosterone may also decrease the frequency and severity of my headaches. I also consent to having estradiol pellet(s) inserted under my skin to also achieve a steady state of estradiol in my body. The potential benefits of estradiol include possible elimination of my mood swings, anxiety and irritability, cardiovascular protection and protect from developing colon cancer and brain dysfunction. I understand that none of these potential benefits are guaranteed.

Risks I understand that the above potential benefits come with some risks. These risks include, but are not necessarily limited to the following: bleeding, infection and pain at the insertion site; lack of effect (from lack of absorption). Estrogen effects may include: breast tenderness and swelling especially in the first three weeks; water retention; increased growth of estrogen dependent tumors (fibroids, endometrial cancer, breast cancer). Testosterone effects include: birth defects in babies exposed to testosterone during their gestation; increase in hair growth on the face; growth of liver tumors, if already present; change in voice and/or clitoral enlargement – both of which are reversible.

In a small number of patients, the body may convert testosterone to DHT which can cause acne or hair loss. The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and cause bleeding. If I have a uterus, I must take progesterone or risk abnormal endometrial cells or in rare cases endometrial cancer.

Charges I understand there is a charge which varies depending on the number of pellets I receive. The precise amount is to be determined by my medical provider. I understand payment is due in full at the time of service.

By signing below, I certify that I have read and understand the above and that I have been encouraged to ask any questions regarding pellet therapy and all of my questions have been answered to my satisfaction. I also acknowledge that the risks and benefits of this treatment have been explained to me and that I may experience one or more of the complications listed above. I accept these risks and benefits and consent to the insertion of hormone pellets under my skin.

_____	_____
Patient Name	Date of Birth
_____	_____
Patient Signature	Date

Consent for Hormone Implantation

1. I, _____ (Patient Name), authorize _____ (Treating Provider)

   or a designated medical professional, Physician or Practitioner to perform the following operation or procedure: STERILE SURGICAL PLACEMENT OF HORMONE PELLETS UNDER THE SKIN.

2. I understand the reason for the procedure is: hormone replacement therapy using Estradiol and/or Testosterone.

3. RISKS: Risks that may be associated with this procedure include, but are not necessarily limited to the following: bleeding, infection, pellet expulsion, indentation, scarring, nerve injury, bruising and/or discomfort. In addition, risks associated with hormone replacement include, but are not limited to: increased growth of existing cancers, thickening of the blood, decreased sperm count, breast tenderness and swelling, water retention, birth defects, facial hair growth, and aggravation of existing fibroids or polyps.

4. LOCAL ANESTHESIA: The administration of anesthesia also involves risks; most importantly, a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the medical professional, physician or practitioner responsible for these services.

5. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure any condition I may have.

6. PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

7. PROVIDER'S DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____ _____
Treating Provider Signature Date

Ovarian Cancer Waiver
for Estradiol Pellet Therapy

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

bio-identical Estradiol replacement therapy with _____ even though I
(Treating Provider)

have a history of ovarian cancer. I understand that such therapy is controversial and that many doctors believe that Estradiol replacement in my case is contraindicated. My Treating Physician has informed me it is possible that taking estrogen (Estradiol, Estriol or Estrone), progesterone, or growth hormone could possibly cause cancer, or stimulate existing ovarian cancer (including one that has not yet been detected). Accordingly, I am aware that ovarian cancer or other cancer could develop while on pellet therapy.

These issues have been explained thoroughly and to my satisfaction. I have also been provided additional information resources on the issue, including but not necessarily limited to information published by the American Cancer Society (https://www.cancer.org/cancer/cancer-causes/medical-treatments/menopausal-hormone-replacement-therapy-and-cancer-risk.html).

Based on this and other information, I have assessed this risk, and I have decided that the potential benefits of hormone therapy outweigh the risks. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Physician.

I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This document is in addition to the separate informed consent for treatment, which I have also completed and signed.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date

Breast Cancer Waiver
for Estradiol Pellet Therapy

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

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

even though I have a history of breast cancer. I understand that such therapy is controversial and that many doctors believe that Estradiol replacement in my case is contraindicated. My Treating Physician has informed me it is possible that taking estrogen (Estradiol, Estriol or Estrone), progesterone, or growth hormone could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

These issues have been explained thoroughly and to my satisfaction. I have also been provided additional information resources on the issue, including but not necessarily limited to information published by the American Cancer Society (https://www.cancer.org/cancer/breast-cancer/living-as-a-breast-cancer-survivor/menopausal-hormone-therapy-after-breast-cancer.html).

Based on this and other information, I have assessed this risk, and I have decided that the potential benefits of hormone therapy outweigh the risks. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Physician.

I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This document is in addition to the separate informed consent for treatment, which I have also completed and signed.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date

MAMMOGRAM WAIVER for ESTRADIOL and TESTOSTERONE PELLET THERAPY

I,_____, voluntarily choose to undergo implantation of

Bio-identical Estradiol and Testosterone pellet therapy with _____,

Treating Provider.

For today's appointment, I **do not** have a Mammogram Report for this reason:

____My decision not to have one. Reason_____

____My doctor's decision to not have one, Dr._____. Please provide a note from the aforementioned physician outlining the rationale.

____Unable to provide report at this time.

Mammogram report information: Date of Mammogram 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 a mammogram since I receive estrogen. _____ (initials of patient)

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body.

I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions.

_____ _____

Patient Signature Date

_____ _____

Treating Provider Signature Date

PAP and TRANSVAGINAL ULTRASOUND WAIVER for ESTRADIOL and TESTOSTERONE PELLET THERAPY

I,_____, voluntarily choose to undergo implantation of subcutaneous bio-identical Estradiol and Testosterone pellet therapy with _____

(Treating Provider)

For today's appointment, I **do not** have a

____PAP Smear report for this reason:

____My decision not to have one. Reason_____.

____My doctor's decision to not have one, Dr._____. Please provide a note from the aforementioned physician outlining the rationale.

____Transvaginal Ultrasound for this reason:

____My decision not to have one. Reason_____.

____My doctor's decision to not have one, Dr._____. Please provide a note from the aforementioned physician outlining the rationale.

____Not indicated.

____Unable to provide report at this time.

Pap report information:

Date of Pap Smear report:_____

My results were: ____Normal ____Abnormal

Transvaginal Ultrasound Information:

Date of Transvaginal Ultrasound:_____

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 a pap and/or Transvaginal Ultrasound since I receive estrogen. _____(initials of patient)

PAP and/or Transvaginal Ultrasound are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a PAP and/or Transvaginal Ultrasound may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of increase of such undetected cancer.

I acknowledge and agree that I have been given adequate opportunity to review this document and ask questions.

_____ _____

Patient Signature Date

_____ _____

Treating Provider Signature Date