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 info@esprithealthclinic.com or

Fax 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!

MALE PATIENT INFORMATION

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

Date of Birth: _____

StreetAddress: _____

City: _____ State: _____ Zip Code: _____

HomeTelephone: _____ 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

StreetAddress: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

BusinessTelephone: _____

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'sName:

LAST FIRST MIDDLE

Spouse's Date of Birth _____

Spouse'sEmployer:

BusinessTelephone: _____

In case of an emergency, whom should we notify? ContactName: _____
Contact
Information: _____
HOME TELEPHONE CELLPHONE 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:

Prostate & Testicular History

Age of first intercourse experience: _____

Are you currently sexually active: ☐ YES ☐ NO

Have you had any sexually transmitted diseases (STDs): ☐ YES ☐ NO

Please list: _____

_____

Have you had a sperm count: ☐ YES ☐ NO
What were the results of the sperm count: _____

Have you had the mumps: ☐ YES ☐ NO
When did you have the mumps: _____

Have you ever had testicular cancer: ☐ YES ☐ NO
What type of treatment did you receive: _____

Do you have prostate problems: ☐ YES ☐ NO

Do you have or have you had prostatitis: ☐ YES ☐ NO

Is your prostate enlarged: ☐ YES ☐ NO

Have you ever had prostate cancer: ☐ YES ☐ NO
What type of treatment did you receive: _____

Have you had blood in your urine: ☐ YES ☐ NO
If yes, when did this occur: _____
Please describe treatment used: _____

_____

Do you have bladder or kidney issues: ☐ YES ☐ NO
If yes, please describe current treatment, if any: _____

_____

Do you have erectile dysfunction: ☐ YES ☐ NO
If yes, please describe: _____

_____

Are you suffering from the following (please check all that apply)

Fatigue:	☐ YES	☐ NO
Decrease of memory:	☐ YES	☐ NO
Decrease in energy level:	☐ YES	☐ NO
Decrease in sexual desire:	☐ YES	☐ NO

Are you suffering from the following (please check all that apply)

Anxiety:	☐ YES	☐ NO
Irritability:	☐ YES	☐ NO
Mood swings:	☐ YES	☐ NO
Migraines:	☐ YES	☐ NO
Memory loss:	☐ YES	☐ NO
Foggy thinking:	☐ YES	☐ NO
Muscle loss:	☐ YES	☐ NO
Poor response to exercise:	☐ YES	☐ NO
Poor recovery from exercise:	☐ YES	☐ NO

Please describe the way in which these issues have been dealt with:

_____

_____

_____

_____

Do you initiate intercourse:	☐ YES	☐ NO
Is intercourse satisfying:	☐ YES	☐ NO
Do you achieve orgasm:	☐ YES	☐ NO
Do you suffer from premature ejaculation:	☐ YES	☐ NO
How often do you have intercourse:	_____	
Is your sex drive similar as it was five years ago:	☐ YES	☐ NO

Please describe:

_____

_____

List any other sexual dysfunctions:

_____

_____

Have you experienced weight gain in the last 1-2 years: ☐ YES ☐ NO

If yes, please describe: _____

_____

_____

Have you lost more than 10 pounds in less than a month: ☐ YES ☐ NO

If yes, why: _____

Have you ever been tested for HIV/AIDS: ☐ YES ☐ NO

Are you HIV positive: ☐ YES ☐ NO

If yes, when did this occur: _____

Please describe:

_____

_____

Have you fathered any children: ☐ YES ☐ NO

If yes, how many: _____

Have you ever had your testosterone level taken in the past: ☐ YES ☐ NO

If yes, why: _____

Please check the box that best describes your sexual orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual

MEDICALHISTORY

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 or stroke: ☐ YES ☐ NO

Have you ever had lung cancer: ☐ YES ☐ NO

If yes, please describe treatment used: _____

_____

Have you ever had colon polyps: ☐ YES ☐ NO
If yes, please describe treatment used: _____

_____

Have you ever had stomach/intestinal cancer: ☐ YES ☐ NO

If yes, what type: _____
Please describe treatment used: _____

Have you ever had leukemia or lymphoma: ☐ YES ☐ NO

If yes, what type: _____
Please describe treatment used: _____

_____

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:

☐ HepatitisA ☐ HepatitisB ☐ HepatitisC ☐ 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

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

Do you have a **lung disease**: ☐ YES ☐ NO

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

Do you have **lupus, scleroderma, collagen disease**: ☐ YES ☐ NO

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Have you had any **major accidents**: ☐ YES ☐ NO

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

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

_____

Have you ever had any problems with your blood ☐ YES ☐ NO
If yes, please list the blood problems (such as anemia and excess blood cells: _____

_____

Have you ever had multiple myeloma: ☐ YES ☐ NO
Please describe treatment used: _____

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

_____

_____

_____

_____

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

If yes, please explain: _____

_____

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 PhoneNumber: _____

Are you currently taking any medications: ☐ YES ☐ NO

Please list the medications you 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

SOCIALHISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please to 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

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)

Male 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							
Sleep Problems							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Decrease in beard growth							
Depression							
Anxiety							
Muscle Weakness							
Excessive Sweating							
Nervousness							
Decrease in Muscle Strength							
Muscle Pain							
Joint Pain							
Foggy Mind							
Loss of Well Being							
Poor Results from Exercise							
Night Sweats							

Informed Consent for Male Testosterone 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 man makes in his own body but to a lesser degree with age. Bio-identical hormones have the same effects on the body as one's own hormones.

Benefits Advantages of testosterone therapy for men include: a) behavioral changes including decreased depression, decreased anxiety and irritability, increased energy and motivation, mood stabilization, better coping, improved self-image and self-worth, and enhanced stamina; b) improved cognitive function so one is no longer operating "in a fog," improved short-term memory and greater focus on tasks; c) physical effects such as decreased total body fat, increased lean body mass, increased muscle mass, and increased bone mass; and, d) sexual benefits such as increased libido, increased early morning erections, increased firmness, and duration of erections.

Risks I understand that the potential benefits come with some risks. Certain hormone pellets are FDA approved and others regulated and monitored.

Other risks include, but are not necessarily limited to: increased growth of existing prostate cancer. For this reason, a rectal exam and prostate specific antigen blood test must done before starting testosterone and 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 cause an increase in hemoglobin and hematocrit, or "thickening of the blood." A complete blood count (Hb & Hct.) should be done at least annually to monitor and diagnose this problem. This condition can be reversed by donating blood periodically.

I also understand the additional concern, especially in younger men, of suppressed sperm development and sperm count with a dramatic reduction while a person is on testosterone therapy. Based on information known to date, this appears to be reversible. In most cases, once the testosterone is discontinued, the sperm count is restored, usually in 3-6 months. This is **extremely important** in younger men taking testosterone therapy. I understand that I have been encouraged to produce samples and have them frozen, just in case there is any permanent long-term effect on my sperm count. I have also been encouraged that, if I am concerned about future fertility, I should have a semen analysis prior to initiation of testosterone therapy. Testosterone administration is not to be used as a form of male contraception.

As with any form of implant therapy, there is a risk of infection, bruising, or bleeding at the insertion site. Instructions on the post-pellet recommendation sheet must be followed to avoid such risk.

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.

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 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.

Patient Name	Date of Birth
Patient Signature	Date

Consent for Hormone Implantation

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

Prostate Exam Waiver
for Testosterone Pellet Therapy

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

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

For today's appointment, I **have not** provided you with a prostate exam report, due to the following reason:

☐ My decision not to have a prostate exam. Reason _____

☐ I am unable to provide it at this time.

Prostate Exam report information:		
Date of Prostate Exam 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 prostate exam since I receive testosterone.
_____(initials of patient)

A prostate exam is the best single method for detection of early prostate cancer. I understand that my refusal to submit to a prostate exam may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of such undetected cancer.

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

Prostate Cancer Waiver
for Testosterone Pellet Therapy

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

bio-identical testosterone pellet therapy with _____, even though I
(Treating Provider)

have a history of prostate cancer. I understand that such therapy is controversial and that many doctors believe that testosterone replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking testosterone or growth hormone could cause cancer, or stimulate existing prostate cancer (including one that has not yet been detected). Accordingly, I am aware that prostate 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 with additional information and resources on the issue, if requested.

Based on this and other information, I have assessed the risks, 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 the opportunity review this document and 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