

**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:*

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How did you hear about us:

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### SYMPTOM CHECKLIST

Please indicate how often you have the following

Night sweats:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Hot flashes/hot flushes:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Pain with intercourse:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Vaginal dryness:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Sleeping problems:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Urine leaks when you cough or sneeze:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Difficulty concentrating/memory loss:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Mood swings:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Migraines:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Depression:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Anxiety:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Decrease in sexual desire:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Decrease in energy level:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Loss of memory:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Foggy thinking:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Muscle and/or joint pain:	<input type="checkbox"/> Frequently	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never

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

Herbal medications/supplements	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please specify how: _____		
Change of diet:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please specify how: _____		
Layered clothing:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please specify how: _____		
Increase exercise:	<input type="checkbox"/> YES	<input type="checkbox"/> 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):

- |   |                                    |                                    |                                     |
|---|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Pills          | <input type="checkbox"/> IUD       | <input type="checkbox"/> Foam      | <input type="checkbox"/> Condoms    |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Implants       | <input type="checkbox"/> Depo      | <input type="checkbox"/> Provera   |                                     |
| <input type="checkbox"/> Other: _____   |                                    |                                    |                                     |

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

- |   |                                    |                                    |                                     |
|---|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Pills          | <input type="checkbox"/> IUD       | <input type="checkbox"/> Foam      | <input type="checkbox"/> Condoms    |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Implants       | <input type="checkbox"/> Depo      | <input type="checkbox"/> Provera   |                                     |
| <input type="checkbox"/> 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 all that apply:

- |                                       |                                   |                                    |  |
|---------------------------------------|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Gardnerella  | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Condyloma | <input type="checkbox"/> Bacterial Vaginitis |
| <input type="checkbox"/> Yeast        | <input type="checkbox"/> PID      | <input type="checkbox"/> Herpes    | <input type="checkbox"/> Chlamydia           |
|                                       |                                   | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Warts               |
| <input type="checkbox"/> 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):

- |   |                                       |  |                                      |
|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Repeated Pap Smear     | <input type="checkbox"/> Colposcopy   | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Cone Biopsy |
| <input type="checkbox"/> Cryosurgery (freezing) | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Loop Excision |                                      |

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

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Have you ever had a <b>blood transfusion</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have <b>asthma, emphysema or chronic bronchitis</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had <b>leukemia</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had <b>lymphoma</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had <b>colon cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had <b>colon polyps</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had <b>multiple myeloma</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had <b>lung cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had <b>rectal cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had <b>breast cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> 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):

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

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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 you are currently taking and the dosage amount:

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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: ☐ YES ☐ NO

Do 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 <b>breast cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>colon cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>ovarian cancer</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>osteoporosis</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>diabetes</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>hypertension</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>heart disease</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
Do you have a family history of <b>kidney disease</b> :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, with who in your family history: _____		
At what age did your mother go through menopause:	_____	



## 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							



### Authorization for Release of Medical Information

According to HIPAA and Governmental rules all patients are asked to sign this release form indicating that you understand that our office follows all HIPAA rules with respect to protected health information.

I hereby authorize the use/disclosure of my health information as described below, including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

Records which may be released include: all medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports.

I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy delivered in person, by mail, email or fax of this authorization is as valid as the original.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person(s)/organizations authorized to receive and use this information:

☐ Insurance Company (If checked, please complete "Insurance Information" on back side)

☐ Pharmacy (release of name, date of birth, allergies only)

☐ Significant Other or Family Member: \_\_\_\_\_

I further authorize you to provide to and discuss with your Provider and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

1. I understand that my health care will not be affected if I do not sign this form.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not revoke this authorization, it will automatically expire six months from its date.
3. I understand this is not in relation to requesting medical records for me for another physician. There is a separate form that is filled out for that request which I can obtain by contacting the medical records department.
4. I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date



## Female Release of Medical Records Consent Form

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for your Provider to have your current pap and mammogram report prior to your next HRT appointment.

To: \_\_\_\_\_ Date: \_\_\_\_\_  
Your Doctor's Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Your Name) (Your Doctor's Name)

to disclose and release any individually identifiable health information related to me **from the last 2 years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Mammogram Report Only | <input type="checkbox"/> Ultrasounds              |
| <input type="checkbox"/> Pap Report            | <input type="checkbox"/> Endometrial Biopsy       |
| <input type="checkbox"/> Bone Density          | <input type="checkbox"/> Any current hormone labs |

Are there any restrictions on PHI to be disclosed? Yes No

If yes, please explain: \_\_\_\_\_

**WE DO NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!**

Send To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## HIPAA-Health Insurance Portability and Accountability Act

**YOUR RIGHTS-** Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

**ACCESS TO YOUR PERSONAL HEALTH INFORMATION** - You have the right to inspect and or/obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

**FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES** - With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

**OTHER USES AND DISCLOSURES:** We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence)
- To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)
- For judicial or administrative proceedings (for example pursuant to a court order, subpoena or discovery request)
- For law enforcement purposes ( i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)
- To avert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
- For compliance with worker's compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
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 particular operation or procedure include: bleeding and/or infection
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

## Female Estradiol & Testosterone Hormone Acknowledgement Insertion Form

**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 gland. 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 are advised to 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 and Risks** I have been told I may have 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, protect against Alzheimer's, increase in my energy, my libido, and my sense of well-being. I may also see testosterone decreasing the frequency and severity of my headaches. I have also been told that I may have 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.

The above potential benefits come with some risks. Pellet insertion is not the usual and customary means of hormone replacement. In cases of excessive consumption of synthetic testosterone by males, adverse conditions included heart problems and elevated cholesterol. Pellet therapy is low-dose, non-oral and uses natural testosterone, and is not associated with such problems.

In a rare number of patients, the body will 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.

Side effects or complications are substantially more rare than in the case of non-bioidentical hormones, but may include: bleeding, infection and pain at the insertion site; 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); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice—which is reversible; clitoral enlargement—which is reversible.

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

*My signature below certifies that I have read and understood the above and my acknowledgement 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

## PAP and Transvaginal Ultrasound Waiver for Estradiol and 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 **do not** have a

☐ PAP Smear report for this reason:

☐ My decision not to have one.

☐ My doctors 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.

☐ My doctors decision to not have one, Dr. \_\_\_\_\_ Please provide a note from the  
aforementioned physician outlining the rationale.

☐ Unable to provide report at this time.

<p><b>Pap report information:</b></p> <p>Date of Pap Smear report: _____</p> <p>My results were: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>	<p><b>Transvaginal Ultrasound Information:</b></p> <p>Date of Transvaginal Ultrasound: _____</p> <p>My results were: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>
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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 that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or ovarian, endometrial and/or cervical issues) that may be sustained by me in connection with my decision to refrain from obtaining a PAP and/ or Transvaginal Ultrasound. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo a PAP and/ or Transvaginal Ultrasound. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Treating Provider Signature

\_\_\_\_\_  
Date





**Mammogram Waiver  
for Estradiol and 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 **do not** have a Mammogram Report for this reason:

☐ My decision not to have one.

☐ My doctors 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 that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast or uterine issues) that may be sustained by me in connection with my decision to refrain from obtaining a mammogram exam. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo a mammogram exam. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Treating Provider Signature

\_\_\_\_\_  
Date

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Power of Pellets® 2015

**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.

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Physician.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss that may be sustained by me in connection with my decision to undergo Estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed to result from a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my decision to undergo Estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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.

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Physician.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or ovarian, endometrial and/or cervical issues) that may be sustained by me in connection with my decision to undergo Estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my decision to undergo Estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Treating Provider Signature

\_\_\_\_\_  
Date