NEW PATIENT QUESTIONNAIRE

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

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a <u>personal</u> history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type:_____ Year: _____

PRINT NAME **SIGNATURE** **DATE**

Rev Feb 2021

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

COLORADO TRT

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

(Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number	( ) -

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

Signature		Name (please print)		Date	

CONSENT FOR HORMONE REPLACEMENT THERAPY

COLORADO TRT

Please read this form entirely. It contains information to assist you in making a decision to have a specific therapy. Initial indicated line if you understand it. If you do not understand it, do not initial it and each paragraph will be discussed with you separately. There are risks and complications that may result from this therapy, they are rare, but do exist and you must be aware of them.

I, the undersigned, authorize and give my Informed Consent to for the administration of hormone replacement therapy.

Expected Benefits of Hormone Replacement Therapy:

Expected benefits include control of symptoms associated with declining hormone levels.

Possible benefits of this therapy may help prevent, reduce or control physical diseases and dysfunction associated with declining hormone levels through hormonal replacement.

I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.

I understand that my health care provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy.

Risks and Side Effects of Hormone Replacement Therapy:

Some of the following risks/adverse reactions are derived from the official Food and Drug Administration (FDA) labeling requirements for these drugs and for therapeutic drug levels in the blood stream. My health care provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my blood stream and would be within the “normal” or “average” blood concentrations.

General:

I, the undersigned, so hereby agree and give my consent to Colorado TRT to provide medical services that are considered necessary and proper. I acknowledge understanding of the necessary interventions, associated risks, and expected benefits of treatments. I will be willing to discuss with my practitioner the different outcomes that could occur and possible complications. I am aware that other complications could occur that could not be foreseen. Any questions regarding this interventions have been answered to my satisfaction properly prior to my signing this consent form, I have made my decision and agree to treatment voluntarily and freely.

I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection or implant.

I understand that there are risks (both known and unknown) to any medical procedure, treatment and therapy, and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

I understand that medicine is not an exact science and that no guarantees are offered regarding my expected results. I am aware that it is possible that this treatment will not work for me.

_____ initial

Testosterone therapy:

A prescription hormone, given by injection, transdermal cream or implanted pellets.

Risks of testosterone replacement include, but are not limited to: stimulation of benign and malignant prostate tumors. Testosterone replacement is contraindicated in patents with known prostate cancer. But, It is not known whether testosterone replacement therapy will increase the risk of prostate cancer.

_____initial

RBC

Side effects of testosterone replacement may include, but are not limited to: an increase in red blood cell counts, determined by periodic measuring in blood testing. and while the increase is usually only to a normal reference range (which does not pose health risks), a high increase in red blood cells (above the laboratory reference range) can cause potentially life-threatening problems such as stroke and heart attack. I have been advised that my blood should be monitored periodically while I am taking testosterone and that this can be corrected by donating blood or with a therapeutic phlebotomy.

_____initial

Atrophy

An additional concern, especially in younger men, is a reduction in the size of testicles may develop along with the suppression of the development of sperm and decreased sperm count while a person is on testosterone therapy. Another medication, Gonadorelin or hCG ay be required. However, to date, this appears to be, in the majority of men, a reversible process, once the testosterone is discontinued, the sperm count is restored, usually in 3-12 months. This is extremely important in men interested having children while taking testosterone therapy. In this early stage, we encourage men to produce samples and have them frozen, just in case there is any permanent long-term effect in their situation. We have encouraged any men who are concerned about their fertility in the future to have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone administration is not to be used as a form of male contraception.

_____initial

Baldness

Testosterone replacement may also cause male pattern baldness, gynecomastia (breast enlargement), reduce insulin requirements in insulin--dependent diabetics. The concurrent use of testosterone with corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre--existing cardiac, renal or hepatic disease.

_____ initial

HTN

The most common immediate side effects (occurring in approximately no more than 6% of users) include, but are not limited to: acne, application site reaction, headache, hypertension (high blood pressure), abnormal liver function tests, and non--cancerous prostate disorder. Other side effects may include greasy hair and skin, a strong body odor, and aggressiveness.

_____ initial

The above listed risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization and/or extended outpatient therapy to permit adequate treatment.

_____ initial

I understand that I can choose to stop taking testosterone at any time, and that it is advised that I do this with the help of my clinician to make sure there are no negative reactions to stopping. I understand that my clinician may suggest I reduce or stop taking testosterone if there are severe side effects or health risks that can't be controlled.

_____ initial

Alternatives to Hormone Replacement Therapy:

I understand the reasonable alternatives to hormone replacement therapy, which include:

Leaving the hormone levels as they are and doing nothing. Risks may include, but are not limited to: experiencing symptoms of hormone deficiency, and increased risk of aging--related diseases or dysfunction resulting from declining hormone levels. This alternative may result in the need to treat diseases or dysfunction associated with declining hormone levels as they appear clinically.

Treating the symptoms of declining hormone levels as they develop with non--hormonal therapies. Risks may include, but are not limited to: increased risk for aging--related diseases resulting from declining hormone levels.

_____ initial

My Compliance Obligation While Receiving Hormone Replacement Therapy:

I agree to comply with the proposed treatment and therapy as prescribed, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or undergoing a small surgical procedure to place hormone pellets under my skin, and consent to periodic monitoring, when requested, which may include:

Laboratory monitoring of blood or urine chemistries and hormone levels Physical

examinations

Regular screening evaluations

I agree to notify you regarding all signs or symptoms of possible reactions to my therapy.

_____ initial

I agree to take testosterone as prescribed and to tell my clinician if I am not happy with the treatment or am experiencing any problems.

I agree to comply with all other healthy lifestyle activities that have been individually recommended for me. I have completely disclosed my medical history, including prescription and non--prescription medications that I am currently taking or plan to take during my treatment, as well as any other over--the--counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to you. I agree to comply with the recommendations regarding the continuation or discontinuation of these preparations.

In the future, I will receive recommendations in advance from you before stopping any prescribed therapeutic regimens or taking additional preparations that are not recommended by you.

I certify that I am under the care of a physician(s) for any and all other medical conditions. Please note, while Colorado TRT may be treating you for a specific medical condition, Colorado TRT is **NOT** your primary care physician. We are not a replacement for a general practitioner or family practice. We recommend that you continue visits with your medical practice and inform them of all medications you are receiving from this clinic.

_____ initial

Research and Economic Interests:

I understand that the prescribing practitioner is not engaged in any personal research and has no economic interests unrelated to my immediate care or treatment that may affect the physician's choice of treatment or medical judgment.

I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base an informed consent.

I do now attest to reading and fully understanding this form and the contents and clinical meanings of such, and having discussed these procedures with my health care provider, and consent to this treatment. I hereby affix my signature to this authorization for this proposed long--term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meanings of its writing and expectations.

Patient (Print Name): _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____