



Ageless Expressions MedSpa

## Female New Patient Package

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in Ageless Expressions MedSpa as your BioTE Provider. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

**1 week or more before your scheduled consultation:** Get your blood labs drawn at the lab of your insurance company's choice (typically Quest Diagnostics or LabCorp). If you are not insured or have a high deductible, call our office for self-pay blood draws. We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to one week for your lab results to be received by our office.**

### Your blood work panel MUST include the following tests:

- Estradiol
- FSH
- Testosterone Total
- TSH
- T4, Total
- T3, Free
- T.P.O. Thyroid Peroxidase
- CBC
- Complete Metabolic Panel
- Vitamin D, 25-Hydroxy (Optional)
- Vitamin B12 (Optional)
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

### Female Post Insertion Labs needed at 5-6weeks:

- FSH
- Testosterone Total
- CBC
- Estradiol
- Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
- TSH, T4 Total, Free T3, TPO **(Needed only if you've been prescribed thyroid medication)**

## Female Patient Questionnaire & History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Address City State Zip

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

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

### Social:

- ( ) I am sexually active.
- ( ) I want to be sexually active.
- ( ) I have completed my family.
- ( ) My sex has suffered.
- ( ) I haven't been able to have an orgasm.

### Habits:

- ( ) I smoke cigarettes or cigars \_\_\_\_\_ per day.
- ( ) I drink alcoholic beverages \_\_\_\_\_ per week.
- ( ) I drink more than 10 alcoholic beverages a week.
- ( ) I use caffeine \_\_\_\_\_ a day

## Medical History

Any known drug allergies: \_\_\_\_\_

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

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

Medications Currently Taking: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_

Nutritional/Vitamin Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

Last menstrual period (estimate year if unknown): \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

### 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.

### Birth Control Method:

- ( ) Menopause.
- ( ) Hysterectomy.
- ( ) Tubal ligation.
- ( ) Birth control pills.
- ( ) Vasectomy.
- ( ) Other: \_\_\_\_\_

### Medical Illnesses:

- ( ) Polycystic Ovary Syndrome (PCOS)
- ( ) 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: \_\_\_\_\_

# BHRT Checklist for Women

Name: \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

## Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		



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## Female Sexual Function Index (FSFI)

Subject Identifier \_\_\_\_\_

Date \_\_\_\_\_

**INSTRUCTIONS:** These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

### **CHECK ONLY ONE BOX PER QUESTION.**

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

- Almost always or always
- Most times (more than half the time) Sometimes (about
- half the time)
- A few times (less than half the time)
- Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

- Very high or High
- Moderate
- Low
- Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

- No sexual activity
- Very high or High
- Moderate
- Low Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- No sexual activity
- Very high confidence High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- 

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- No sexual activity
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

- No sexual activity
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- No sexual activity
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- No sexual activity
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- No sexual activity
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- Did not attempt intercourse
- Very high High
- Moderate
- Low
- Very low or none at all
- Almost never or never

# Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Today's Date: \_\_\_\_\_

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

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

### My birth control method is: (please circle)

Abstinence      Birth control pill      Hysterectomy      IUD      Menopause      Tubal ligation      Vasectomy      Other

**CONSENT FOR TREATMENT:** I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); 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). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

**BENEFITS OF TESTOSTERONE PELLETS INCLUDE:** Like all other health care, results are not guaranteed and there is no promise that you will achieve any result. Every individual responds to care differently and no guarantee or assurance is made as to the results of care in your case, as care may not improve your condition or result in reducing your symptoms. Patients report increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight. Studies indicate a decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

**ALTERNATIVES:** Alternatives include declining our services and consulting other providers for other options.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I agree that I may be seen by a physician or nurse, who are monitored by and may act pursuant to delegation. I understand that only an appropriately licensed prescribing provider may order medications and has authority to modify the dose or frequency of the medications ordered. I may request to consult with the physician at any time.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name

Signature

Today's Date



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## **Hormone Replacement Fee Acknowledgment**

Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

<b>New Patient Consult Fee</b>	<b>\$125</b>
<b>Female Hormone Pellet Insertion Fee</b>	<b>\$325</b>
<b>Male Hormone Pellet Insertion Fee</b>	<b>\$625</b>
<b>Male Pellet Insertion Fee (<math>\geq 2000\text{mg}</math>)</b>	<b>\$725</b>
<b>Lab Fee for Self Pay</b>	<b>\$250</b>

**We accept the following forms of payment:**

**Master Card, Visa, Discover, American Express, Personal Checks and Cash.**