4510 Medical Center Dr. Suite 314
McKinney, Texas 75069
214-237-4132
214-237-4130
info@empowerwla.com
www.empowerwla.com

1. **Please enter your information.**

First Name: ______ Middle Initials: ______ Last Name: ______ Today's Date ______

Date of Birth: ______ Age: ______ Occupation: ______

Weight: ______

Marital Status:
○ Married ○ Divorced ○ Widow
○ Living with Partner ○ Singe

Address: ______ Apt./Unit #: ______

Mobile Phone: ______ Home Phone: ______ Work Phone: ______

Email: ______

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

May we contact you via E-mail?
○ Yes ○ No

In case of Emergency Contact: ______ Emergency Contact Phone Number: ______

Primary Care Physician's Name and phone number: ______ Primary Physician Address: ______

In the event we cannot contact you by the mean's 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 or Significant Other ______ Relationship ______

Home Phone Number: ______ Cell Phone: ______

Work Phone: ______

2. Social:

- ☐ I am sexually active.
- ☐ I have completed my family
- ☐ I have used steroids in the past for athletic purposes
- ☐ I want to be sexually active.

3. Habits:

	How much?	How often?
Smoking- cigarettes/cigar		
Alcohol		
Recreational drugs		
Tea		
Coffee		

4. Any known drug allergies:

____

5. Have you ever had any issues with anesthesia?

- ○ Yes
- ○ No

If yes, please explain

____

6. Please list any prescribed medications you take:

	Name	Dosage
1		
2		

7. Current Hormone Replacement Therapy:

____

8. Past Hormone Replacement Therapy:

____

9. Please list any nutritional/vitamin supplements you currently take:

	Name of supplement	Dosage
1		
2		

10. **Surgeries, list all and when:**

____
____
____
____

11. **Other pertinent information:**

____
____
____
____

12. **Medical Illnesses: Please tick the boxes which indicate conditions you have had or presently have. If any other conditions, please list them on the box down below:**

☐ Arrhythmia	☐ AIDS/HIV	☐ Angina
☐ Anxiety disorder	☐ Arthritis	☐ Cancer
☐ Depression	☐ Diabetes	☐ Blood clot
☐ Heart Disease	☐ Hepatitis A, B or C	☐ Heart Attack
☐ High Cholesterol	☐ High Blood Pressure	☐ Heart Bypass
☐ Hemochoromatosis	☐ Kidney Disease	☐ Testicular Cancer
☐ Auto Immune Disease	☐ Liver Disease (hepatitis, fatty liver, cirrhosis)	☐ Mood disorder
☐ Prostate Cancer	☐ Pulmonary Emboli	☐ Psychiatric Disorder
☐ Stroke	☐ Thyroid Disease	☐ Trouble passing urine or take Flomax or Avodart
☐ Elevated PSA	☐ Prostate Enlargement	☐ No medical Problems

If cancer: Type and Year

____

13. **Family History: Please tick any family history listed below:**

☐ Heart Disease	☐ Diabetes	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Breast Cancer	

Please explain:

____

14. How did you hear about our clinic?

- ☐ Internet Search
- ☐ Yelp
- ☐ Family/Friend
- ☐ BioTE website
- ☐ Facebook
- ☐ Other

15. Please Answer Below:

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive Sweating				
Sleep Problems				
Increased Need for Sleep				
Irritability				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion/lacking vitality				
Declining Mental Ability to Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased Muscle Strength				
Weight Gain/Belly Fat/Inability to lose weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No results from E.D. medications				

I understand that if I begin testosterone replacement with any testosterone treatment, including pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone pellets should be out of your system in 12 months. By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

______________________________ Signature

______________________________ Date