EvexiPEL®

AMS Checklist - BEFORE HRT

Which of the following symptoms apply at this time?
Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9. **Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14. **Decrease in beard growth**	☐	☐	☐	☐	☐
15. **Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17. **Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Please list any prior hormone therapy?

_____

_____

Recent PSA:_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details.

_____

_____

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:_____

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**

EVEXIAS Medical Centers, PLLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

I acknowledge receipt and understanding of my rights.

PRINT NAME _____ SIGNATURE _____ DATE _____

Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent to Evexias Medical Centers, PLLC to release my protected health information (PHI) to include, but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information, etc. to the following individuals:

Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**

Consent (check ALL that apply):

I consent Evexias Medical Centers, PLLC to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results or financial services at the following [**check ALL that apply**]:

☐ **Call** ☐ **Text** Phone:_____

☐ **Email** address:_____

This consent will expire only with written notification to contact@evexiasmedical.com

Patient Name (*Print Clearly*):_____

Patient Signature:_____ **Date:**_____

If a minor (under 18 years of age)

Parent or Guardian Name (*Print Clearly*):_____

Parent or Guardian Signature:_____ **Date:**_____

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Evexias Medical Centers, PLLC (EMC) appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We expect these payments at time of service. I agree to pay EMC the full and entire amount of treatment given to me or to the above named patient at each visit.

We only accept insurance as a form of payment for lab work. We can file with your insurance company or you can choose to pay our cost. If you choose to have your lab work filed with your insurance company instead of paying our cost, you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. I understand and take full responsibility for any amounts not covered by my insurance carrier(s).

We provide paperwork for Pellet HRT that you can use to submit to your insurance company for reimbursement. I understand that EMC is unable to assist with any additional paperwork or requests made by patients or insurance providers.

Prescriptive medication requires a payment prior to it being ordered and is shipped to the clinic. Prescriptive medication is to be picked up within five business days of notification of its arrival to the clinic. I understand that if my medication expires between the pick up date requirement and the day I pick it up, I must pay in full for a new order of my prescriptive medication. I also understand that refunds or credits are not permitted on any prescriptive medication for any reason.

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call at least 24-hours prior to cancel your appointment. I understand if I *no show* or *cancel* an appointment two times in a row without notifying EMC within 24 hours, I will have to pay a $50 non-refundable fee before scheduling my next appointment.

I have read the above policy regarding my financial responsibility to Evexias Medical Centers, PLLC for providing any and all services to me, or the above named patient. I acknowledge that I am financially responsible for myself, or the above named patient.

Patient Name [PRINT]	**Patient Signature**	**Date**
Guarantor Name [PRINT]	**Guarantor Signature**	**Date**

(If guarantor is not the patient)

TESTOSTERONE PELLET INSERTION CONSENT FORM (MALE)

Patient Name:_____ **DOB:**_____

Bio-identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio-identical hormone pellets are made from yams and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Risks of not receiving testosterone therapy after andropause include but are not limited to:
Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

Side effects may include: Bleeding, bruising, swelling, infection and pain. Lack of effect (typically from lack of absorption). Thinning hair, male pattern baldness. Increased growth of prostate and prostate tumors. Extrusion of pellets. Scarring at insertion site. Keloid scar. Hyper sexuality (overactive libido). Ten to fifteen percent shrinkage in testicle size. There can also be a significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted 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 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 and Hematocrit.) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: 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 (secondary to hormonal decline). Decreased weight (Increase in lean body mass). Decrease in risk or severity of diabetes. Decreased risk of Alzheimer's and Dementia. Decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 insertions.

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

Post-Insertion Instructions for Men

- Your insertion site has been covered with two layers of bandages.
    - Remove the outer pressure bandage in 24 hours. It **MUST** be removed as soon as it gets wet. You may replace it with a bandage to catch any anesthetic that may ooze out.
    - The inner layer is a steri-strip. It should not be removed before **7 days**. If the steri-strip comes off you may replace it with a band-aid or butterfly bandage.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **5-7 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **7 days**, (running, riding a horse, etc.). If you had a flank insertion, no strenuous flank area exercises for 7 days (abs, twisting, golf, etc.).
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness at the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience active bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any active bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

- **Remember to go for your post-insertion blood work 5weeks after the insertion. This is VERY important!!**
- Most men will need re-insertions of their pellets **5-6 months** after their initial insertion.
- Please call to make an appointment for a re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion and not a consultation.

New patients: Please make a follow up lab review appointment in 6 weeks:

I acknowledge that I have received a copy and understand the instructions on this form.

_____	_____	_____
PRINT – PATIENT NAME	**SIGNATURE – PATIENT NAME**	**DATE**

EvexiPEL®

TREATMENT PLAN

Patient Name:_____ **DOB:**_____

The following medications and/or supplements are an integral part of your BHRT therapy and may be purchased in our office. For refills, you may stop by or call and we can mail them to you.

SUPPLEMENTS

Unless specified, these supplements can be taken anytime of day without regards to meals.

_____ ADK ☐ 1 per day ☐ 2 per day *(Take with fatty food such as egg, dairy, etc.)*

_____ B Complex ☐ 1 per day ☐ 2 per day

_____ DIM 150 mg ☐ 1 per day ☐ 2 per day ☐ 3 per day

_____ Iodine 12.5 mg ☐ 1 per day ☐ 2 per day ☐ Start in 2 weeks

To prevent potential detox symptoms (e.g. headache, fatigue), ALSO take:

- ✓ 2000 – 4000 mg Vitamin C: *daily*
- ✓ B-complex: *daily*
- ✓ ½ tsp Celtic or Mediterranean sea salt in warm water; *drink daily for 2 weeks*

_____ Probiotic (Type:_____) ☐ 1 per day ☐ 2 per day

_____ Other:_____ ☐ 1 per day ☐ 2 per day

_____ Other:_____ ☐ 1 per day ☐ 2 per day

PRESCRIPTIONS

_____ Nature-Throid:_____mg every morning. This should be taken on an empty stomach. Please wait 45-60 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements.

_____ *Wean off Synthroid/levothyroxine/Armour: Alternate your desiccated thyroid (Nature-Throid) every other day with Synthroid/levothyroxine/Armour for three (3) weeks then go to every day on your desiccated thyroid.*

_____ Other:_____

_____ Other:_____

_____ Wean off your antidepressant (*Wean Protocol Provided).*

INSTRUCTIONS

_____ BHRT Pellet Post Insertion Instructions reviewed and provided.

_____ Additional Instructions below reviewed and provided.

_____

_____

_____

Do not stop prescriptions or recommended supplements without advising your practitioner.
I acknowledge that I understand all information and instructions and that a copy has been provided.

Print Name	**Signature**	**Date**
_____	_____	_____