

LOW T NATION TESTOSTERONE MEN'S INTAKE FORM

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ CELL #: _____ HOME #: _____

DRIVERS LIC# (NY, KY, AL, IN, CA) _____ BIRTH DATE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

EMAIL ADDRESS: _____

MARITAL STATUS: () SINGLE () MARRIED () DIVORCED () WIDOWED () SEPERATED

PATIENTS OCCUPATION: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____

CONTACT #: _____) CELL) HOME

OCCUPATION: _____

EMPLOYER: _____

I am interested in discussing the following programs:

Testosterone Replacement Therapy
HGH Peptide Therapy (Ipamorelin or Ibutamoren)
Stem Cell Replacement Therapy
MIC / Lipo-B12 / GAC / Vit D etc.
Meal Replacement

IV Therapy
Weight Loss
ED Therapy (Orals, PT-141, Tri-Mix, Shockwave)
BPC-157 or TB-500 Peptide Therapy
Nutritional Counseling

Health History Questionnaire:

Primary Care Doctor (PCP): _____ Phone number: _____

Personal Health History – Check all that apply.

General	Diabetes		High Cholesterol		Unwanted Weight Loss	
Cancer	Personal History of Cancer		Family History of Cancer		Autoimmune Disorder	
Cardiovascular	Heart Failure		Heart Attack		Heart Murmur	
	Vascular Disease		Blood Clots		Edema	
	Hypertension		Irregular Heartbeat		Congestive Heart Failure	
Respiratory	Sleep Apnea		Shortness of breath		Asthma / COPD	
	Bronchitis		Pneumonia		Allergies	
Gastrointestinal	Lactose Intolerance		Gall Bladder		Gall Stones	
	Chronic Diarrhea		Chronic Constipation			
Genitourinary	Prostate Cancer		Familial Prostate Cancer		Overactive Bladder	
	Painful Urination		Decreased urinary force		On/Off Urine Flow	
	Enlarged Prostate (BPH)		Blood in Urine		Kidney/Bladder History	
Infection	Kidney /Bladder		Liver			
Psychiatric	History of Depression		Personality Disorder			

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers.

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Allergies: _____ No Known Allergies Or List Allergies and Reaction

Surgeries:

Year _____ Surgery/Reason _____

Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: _____ None _____ Mild _____ Occasional vigorous exercise _____ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

Have you used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past? Please be completely truthful with your response, it is critical to diagnose and prescribe correctly.

Rate your quality of sleep: 1-Worst 10-Best

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire

Alcohol: ____ Yes Number of drinks per week: _____ ____ No

Tobacco: ____ Yes ____ Cigarettes ____ Cigars ____ Chewing How many/much: _____ ____ No

Illicit drug use: ____ Yes Explain _____ ____ No

Vitals

Weight _____ Height _____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased concentration ____ Yes ____ No

Difficulty learning new things ____ Yes ____ No

Memory loss ____ Yes ____ No

Moodiness ____ Yes ____ No

Depression ____ Yes ____ No

Increasing fatigue ____ Yes ____ No

Decreasing energy ____ Yes ____ No

Daytime sleepiness ____ Yes ____ No

Poor sleep habits ____ Yes ____ No

Erectile dysfunction ____ Yes ____ No

I have had testosterone checked previously ____ Yes ____ No

I have used testosterone previously ____ Yes ____ No

If yes, date(s): _____ Type: _____ Usage: _____



ACH Debit Authorization Form

I _____ authorize Low T Nation to charge my credit card for services rendered
PRINT FULL NAME not to exceed the amount shown.

Lab Charge Amount: \$ _____ USD

Monthly Charge Amount: \$ _____ USD

CREDIT CARD

CARD NUMBER _____

CARD CVC _____

EXPIRATION DATE _____

BILLING ADDRESS _____

BILLING ZIP CODE _____

NAME ON CARD _____

(As it appears on card)

SIGNATURE **DATE**

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT/hCG THERAPY (TRT)

It is important to understand that all medicine is an inexact science. Although we will carry out your treatment carefully, results may vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider. Please review the following statements, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all your questions to your satisfaction.

Directions: Initial beside each statement that you have read, understand and agree with.

_____ 1. This is my consent LOW T NATION, LLC., including any physician or nurse who works with the company, to begin my treatment for Testosterone Replacement Therapy.

_____ 2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3-#7)

_____ 3. Extra fluid in the body- This can cause problems for patients with heart, kidney or liver disease.

_____ 4. Sleep disturbance - This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.

_____ 5. Prostate enlargement- this may cause problems with urinating.

_____ 6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____ 7. I understand that I will have periodic blood tests to monitor my blood levels.

_____ 8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____ 9. I have had an opportunity to discuss with LOW T NATION, LLC. and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers.

_____ 10. I understand that the physical exam by LOW T NATION, LLC. does NOT replace a full physical exam by a personal physician.

____11. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician, LOW T NATION, LLC. will assist in locating one for me.

____12. Family Planning for the patient has been discussed.

____13. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility.

____14. I have been trained on how to administer intramuscular and subcutaneous injections from a licensed medical practitioner who is approved to perform such tasks.

____15. I agree that, while a patient of LOW T NATION, LLC., I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by LOW T NATION, LLC. during my treatment plan. At any time, if use of these items is discovered, I understand I will be discharged as a patient of LOW T NATION, LLC..

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Notes: