LOW T NATION FEMALE 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

PATIENT OCCUPATION: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT:_____

CONTACT #: _____ ◯ CELL ◯ HOME

OCCUPATION:_____

EMPLOYER: _____

I am interested in discussing the following programs:

- ☐ Hormone 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
- ☐ Sexual Function Therapy
- ☐ BPC-157 or TB-500 Peptide Therapy
- ☐ Nutritional Coaching

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 (non-breast)	☐	Family History of Cancer (non-breast)	☐	Personal or Family history of Breast Cancer	☐
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	☐		
	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 any hormone (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 ◯

LOW T NATION

Lifestyle Questionnaire

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

Tobacco: ☐ Yes _____ Cigarettes ____ Cigars ____ Chewing ☐ No

Illicit drug use: ☐ Yes Explain_____ ☐ No

Vitals

Weight _____ Height_____

Previous menstrual cycle start date: _____

SYMPTOMS OF LOW HORMONE 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

Breast tenderness ◯ Yes ◯ No

Hot flashes ◯ Yes ◯ No

Poor sleep habits ◯ Yes ◯ No

Painful intercourse ◯ Yes ◯ No

I have had my hormone levels checked previously ◯ Yes ◯ No

I have taken hormone replacement previously ◯ Yes ◯ No

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

LOW T NATION

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 HORMONE REPLACEMENT

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 Hormone 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 Hormone Replacement Therapy. You should also be aware of the alternatives to Hormone 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 Hormone 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. Hair growth and/or hair loss.

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

_____14. 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: