PATIENT REGISTRATION

Please Provide Us With A Copy Of Your Insurance Card And Drivers License

Section I Patient Information

Last Name: ______________________ First Name: ___________________ MI: ________
Billing Address: ___________________________________ Apt#: ___________
City: __________________________ State: ________________ Zip: _________________
Home phone:( )___________________ Work phone:( )__________________
Cell phone: ( )____________________
Employer Name: ____
Date of Birth: ________Age___ Sex: M F
Drivers License #: ______________________ State: ________
Marital Status: S M W D O
Referred by: ______________________ Previous Physician: _________________________

Section II Insurance Information

(Person whose social security number the insurance would be under or person financially responsible)

Employer: _________________________________ Phone: _______________________
Name of Insurance: ____________________ Insurance ID Number: _______________

Section III/ Emergency Contact

1st Emergency Contact:
Name: ____________________________________ Relationship: _____________________
Address: _____________________ City: ________________ State: _______ Zip:_______
Home phone: ( )__________________ Work phone: ( )______________________

2nd Emergency Contact: (Person not residing at same residence)
Name: ____________________________________ Relationship: _____________________
Address: _____________________ City: ________________ State: _______ Zip: _______
Home Phone: ( )____________________ Work phone:( )_______________________

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

Initials

_____ 1. I authorize the release of medical information necessary to process my insurance claim.

_____ 2. I understand that I am financially responsible for all charges incurred including any co-payments or co-insurance that may be required per agreement with my insurance company or payment-in-full at the time of service.

_____ 3. I authorize medical treatment for the minor children listed above, in the event of an emergency when I cannot be contacted.

_____ 4. Should I be referred to another physician, I authorize release of my medical records and discussion of my care between physicians and other health care professionals.

_____ 5. I certify that all of the above information is true and correct to the best of my knowledge.

_________________________ _________________

*** SIGNATURE REQUIRED*** **DATE**

(04/23)

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Dr. Gayle Frazzetta, M.D.

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use of disclosure of patient health information. The following summarizes the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment and health care operations purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

We are permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives or close personal friends when the information is relevant to individual's involvement with your care or instructions for care. We will disclose your PHI when we refer you to other physicians or health providers. We reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI along with the right to request portions of your PHI be amended. Our practice is not obligated to agree to request restrictions or to amend your PHI in the manner you request. You have the right to inspect and receive a copy of your PHI with a reasonable charge for the labor and costs associated with copying your PHI. You have the right to receive an accounting of disclosures of your health information.

Authorization for other uses

Our practice will make other uses and disclosure of your protected health information ONLY after obtaining your written authorization. If you authorize a use not contained in this notice, you many revoke your authorization at any time by notifying us in writing that you request to revoke your authorization.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting Dr. Gayle Frazzetta, 224 S. Nevada Ave. Montrose CO 81401, 970-252-9644 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgment

I acknowledge that I have signed and received a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

____ __________________

Patient Signature Date

HEALTH HISTORY QUESTIONNAIRE

For Doctor's Use

GENRAL INFORMATION

Name:

Date:

Age:

Occupation:

Education: (grade completed)

Special interest or hobbies:

How did you hear about our practice?

OTHER MEMBERS OF HOUSEHOLD

	Name	Age	Relationship	Major Medical Problems
1.				
2.				
3.				
4.				
5.				

FAMILY HEALTH HISTORY

List any blood related family member (parent, grandparent, aunt, uncle, sibling, child) who has had any of the following:

Allergy, Asthma, Eczema ______

Migraine ______

Blood Clotting/Bleeding Problem ______

Osteoporosis ______

Glaucoma ______

Diabetes ______

Colon Polyp. ______

High Blood Pressure ______

High Cholesterol ______

Stroke ______

Alcohol/Drug Abuse ______

Depression/Suicide ______

Psychiatric Problem ______

Birth Defect/Genetic Disease ______

Cancer: (Include location and age at diagnosis) ______

Heart Disease/Attack: (Include type and age at diagnosis ______

YOUR MEDICAL HISTORY

HOSPITALIZATIONS, OPERATIONS AND INJURIES. List cause or type. Exclude normal pregnancies. YEAR

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

RECURRENT, SERIOUS, OR CHRONIC ILLNESS, current or past requiring long term medications or repeated doctor visits

1. ______
2. ______
3. ______
4. ______

HAVE YOU EVER HAD?

- ☐ Asthma
- ☐ Anemia
- ☐ High blood pressure
- ☐ Heart disease/attack
- ☐ Rheumatic fever
- ☐ Mitral Valve Prolapse
- ☐ Heart murmur
- ☐ Thyroid problems
- ☐ Ulcer
- ☐ Liver disease, hepatitis, jaundice
- ☐ Gallbladder problems
- ☐ High cholesterol or triglycerides
- ☐ Pneumonia
- ☐ Kidney stones
- ☐ Eating disorder/bulimia/anorexia
- ☐ Tubal or pelvic infections
- ☐ Seizures
- ☐ Abnormal PAP smear
- ☐ Blood transfusion
- ☐ Back trouble
- ☐ Migraine headaches
- ☐ Drug or alcohol problems
- ☐ Depression
- ☐ Nervous breakdown/mental illness
- ☐ Suicide attempt
- ☐ Been in counseling or therapy
- ☐ Precancerous skin lesions

MEDICATIONS: List any medications that you use at lease once a month. This included prescription medicines, birth control pills, And non prescription medicines such a pain reliever, vitamins, antacids, laxatives, sinus medication, etc.

DO YOU HAVE PRESCRIPTIONS FOR PAIN MEDICINE FROM ANY OTHER DOCTOR/HEALTHCARE PROVIDER? ___ YES ___ NO

______ ______

______ ______

______ ______

______ ______

ALLERGIES: List any allergies or bad reactions to medications. List medication and type of reaction.

1. ______
2. ______
3. ______

Do you have any allergies to (ie. food, mold, animals, etc.) ______

For Doctor's Use

REPRODUCTIVE HISTORY Women only

Age period began ______ Number of pregnancies ______

Past methods of birth control ______ Miscarriages ______

Exposure to DES ☐ yes ☐ no Abortions ______

Problems with pregnancy ______ Cesarean sections ______

Treatment for infertility ☐ yes ☐ no Living children ______

HISTORY OF ABUSE

Have you ever experienced any physical, emotional, or sexual abuse that you are aware of ? ☐ yes ☐ no

If yes, ______ past ______ current

Was/is the perpetrator a ☐ relationship partner ☐ family member ☐ acquaintance ☐ stranger

SEXUAL HISTORY Those questions are personal, but very important in providing you with good health care.

How many sexual partners of the opposite sex have you had in your lifetime? None 1-2 3-5 5-10 10-20 20+

How many sexual partners of the same sex have you had in your lifetime? None 1-2 3-5 5-10 10-20 20+

Have you ever had a sexually transmitted or venereal disease? (gonorrhea, chlamydia, genital warts, herpes) ☐ yes ☐ no

Have any of your sexual partners been bisexual, IV drug users, or had many previous sexual partners? ☐ yes ☐ no

Have you ever been tested for the AIDS virus? ☐ yes ☐ no Would you like to be tested today? ☐ yes ☐ no

HABITS

Smoking: Do you smoke now? ☐ yes ☐ no

If yes, how many packs per day ______ Would you like to quit? ☐ yes ☐ no

If no, did you smoke in the past? ☐ yes ☐ no

If yes, when did you quit ______ How many packs per day for how long? ______

Alcohol: Number of drinks per week, including beer and wine ______

Any illicit drug use? (Marijuana, Cocaine) ☐ yes ☐ no

Any use of intravenous drugs now or in the past? ☐ yes ☐ no

Do you ride motorcycles or bicycles? ☐ yes ☐ no

Do you wear a helmet? ☐ yes ☐ no

How often do you use seatbelts? ☐ less than 25% ☐ 25-50% ☐ 50-75% ☐ 100%

Do you exercise? If so, how often per week? ______

Are there firearms in your home? ☐ yes ☐ no

HEALTH MAINTENANCE HISTORY

DNR Status:

When was your last: Complete physical exam? ______ Tetanus shot ______ EKG? ______

(Women only) Pap smear? ______ Breast check? ______ Mammogram? ______

When was your last: Flu shot ______ Pneumovax ______

Do you have a living will? ☐ yes ☐ no

WORK EXPOSURE HISTORY

Are you working outside of the home currently? ☐ yes ☐ no

Starting with you most recent job, what type of work have you done?

	Type of work	From	To
1.			
2.			
3.			

OTHER HEALTH CARE PROVIDERS Who else have you seen for your health care in the past five years?

Year	Name of health care provider	Location: City, State	Primary problems cared for

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, ______________________________, hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

The information is to be disclosed by:	And is to be provided to:
	Montrose Wellness Center
	224 South Nevada
	Montrose, CO 81401
	(970) 252-9644 Phone (970) 252-9646 Fax

Patient Name (Last, First, MI) ______________________________ DATE OF BIRTH ___/___/___

The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (specify) ____________

The Information to be disclosed from my health record: *(check appropriate box(es))*

☐ Entire Record

☐ Only information related to (specify) ______________________________

____

☐ Only the period of events from ____________ to ____________

☐ Other (specify) ______________________________

If you would like any of the following sensitive information disclosed, check the applicable box(es) below

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (other than Psychotherapy Notes)

I understand that I may revoke this authorization in writing submitted at anytime, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminated one year from the date of my signature unless I have specified a different expiration date or expiration event.

____
(Enter if different from one year after date below)

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient	Date
Signature of Authorized Representative	**Date**

Gayle Frazzetta M.D.

224 South Nevada • Montrose, CO 81401 • *Phone* (970) 252-9644 • *Fax* (970) 252-9646

Patient Name:____________________________ **Date:**______________

Advance Beneficiary Notice of Noncoverage (ABN)

The services you are receiving today are not likely covered by your insurance.

- You agree to pay Montrose Wellness Center for services rendered at the time of service.
- You may request the appropriate insurance forms so that you can submit them to your insurance for possible reimbursement.

I agree to the above:

Signature:______________________________________Date:_______________

Consent for Treatment

- I authorize and give consent to Montrose Wellness Center (Dr. Frazzetta) for evaluation and treatment of my symptoms by the ordering of testing and administration of hormones. The goal and possible benefits of this therapy are to individually balance hormones for symptom management and possible chronic disease management. I am aware of the importance of my role in this process including knowing the importance of diet, exercise, stress management and healthy relationships. I understand this is not an FDA approved therapy. I certify that I will notify Montrose Wellness Center immediately of any possible symptoms, signs, or possible reactions to my therapy.
- I understand the possible risks of hormone therapy may include an increase risk of heart attacks, strokes, blood clots in the lungs and legs, hormone sensitive cancers or early death.
- I understand the importance of screening tests including; colonoscopy, mammogram, bone density and regular check-ups and will comply with these recommendations. If I choose not to, I understand my risk of not doing so.
- I agree to allow my information to be used anonymously for research purposes.

I agree to the above:

Signature:______________________________________Date:_______________

Hormone Therapy Questionnaire

Name______________________________ DOB_____________ Date__________

Email address:____

How did you hear about us?____

Gender: ☐ Female ☐ Male Age: __________ Primary Provider's Name: ____________

Current Weight: ________(lbs) Current Height: ____________(ft,in) Ideal Weight____________

- **Do you or have you ever had any of the following?**

☐ Heart Disease	☐ Endometriosis	☐ Fibromyalgia
☐ High Blood Pressure	☐ Arthritis	☐ Factor 5 Leiden/ blood clots
☐ High Cholesterol	☐ Depression	☐ Lichen Sclerosis
☐ Diabetes	☐ Anxiety	☐ Autoimmune Disease
☐ Thyroid Disorders	☐ Celiac Disease	☐ Anemia
☐ Osteoporosis	☐ Gastric Reflux/ulcers/gastritis	☐ PCOS
☐ Migraine/ Headaches	☐ IBS/ulcerative colitis/Crohn's	☐ Eating Disorder

Do you smoke? ☐ YES ☐ NO If yes, how many packs a day__________

Do you drink alcohol? ☐ YES ☐ NO If yes, type & weekly intake____________

- **Surgical History**

Please list any surgical procedures and the year____

____

____

- **Family History:** Has anyone in your family had any of the following? Please specify relationship.

☐ Breast cancer	Relationship____________	☐ Alzheimer's	Relationship__________
☐ Uterine cancer	Relationship____________	☐ Stroke	Relationship__________
☐ Prostate cancer	Relationship____________	☐ Hemochromatosis	Relationship__________
☐ Osteoporosis	Relationship____________		

Members of household:

Name	Age	Relationship

- **For women**

  Age of first menstruation: ________ First day of last menstrual period __________
  How many days your period last? ___________________
  How often do you get your period? __________________

  Are you pregnant or planning to get pregnant? ☐ YES ☐ NO

  Are you currently using contraception? ☐ YES ☐ NO Name______________________________

  Any personal history of breast or uterine cancer ☐ YES ☐ NO If Yes:______________________

  Bone Density date:__________________ Results:____________________
  Mammogram date:__________________ Results:_____________________
  Pap smear date: ____________________Results: ____________________
  Colonoscopy date: __________________Results:_____________________
  Last Physical/Blood Test: ____________Results:_____________________

- **For men**

  Prostate exam date: __________________Results:____________________
  PSA blood test date: __________________ Results:____________________
  Colonoscopy date:____________________ Results:____________________
  Last Physical/Blood Test: ______________Results:____________________
  Do you have a family history or personal history of prostate cancer? _____________________
  Do you desire fertility? ____
  How many times do you get up to urinate at night? ___________________________________

- **MEDICATIONS:**

Current Medications/ Reason /Duration of Treatment/ Prescribing Physician

____
____
____
____
____
____

Current Vitamins/Minerals/Herbal Supplements

____
____
____
____
____

ALLERGIES:____

- **Hormone Therapy History:**

Have you received hormone therapy in the past? □ Yes □ No

Are you currently receiving hormone therapy? □ Yes □ No

If yes, what type of hormones you have replaced or balanced?

☐ Estrogen	☐ Progesterone	☐ Testosterone
☐ DHEA-S	☐ Cortisol	☐ Thyroid

In your own words, what you would like to benefit from your treatment?

____

____

Sexual History (check all that apply)

	I have had a new partner in the last 3 years
	My sex life is good
	I have the ability to have an orgasm
	I have never had an orgasm
	I had orgasms before the age of 40 but not now
	I had sexual fantasies in the past
	I still have sexual fantasies
	My sex life has gotten worse after 40
	My sex life has been better after 40
	I have experience using a vibrator
	How often are you sexually active or intimate with your partner: ____________

Social History (check all that apply)

	I am menopausal
	I have completed my family
	I have permanent birth control
	I am married
	I have a partner
	I am in a committed relationship
	I am heterosexual
	I am homosexual
	I am bisexual
	Other:

Exercise History (check all that apply)

	I don't exercise
	I have a very physical job, so I don't exercise in addition
	I exercise every day for ________minutes
	I exercise more than 3 times a week for over 50 minutes
	Normal daily activity is what I consider exercise
	I am a long-distance runner or endurance runner
	I lift weights _______ times a week
	Other:

Diet (check all that apply)

	I eat anything I want
	I don't eat much but gain weight anyways
	I have gained weight in my belly since I turned 40
	I eat a balanced diet, 3 times a day
	I eat 6 small meals a day
	I limit carbohydrates
	I eat a low-fat diet
	Special diet or restrictions
	Type of diet:

Consent for the Evaluation and Treatment for Hormone Balancing Therapy

PLEASE INITIAL EACH HORMONE

Estrogen

________A prescription hormone, given as pellets, tablets or transdermal patch. Possible side effects may include; breast tenderness, fluid retention, vaginal bleeding, acne, headaches, risk of gallstones, enlarge fibroids, thrombosis/clots.

Progesterone

_______A prescription hormone, given by oral capsules or sublingual tablets. Possible side effects may include fluid retention, acne, breakthrough bleeding and mood changes. Progesterone lowers the risk of uterine cancer.

Testosterone

_______A prescription hormone, given by sublingual drops, gel, injection (men) or pellets. Possible side effects may include acne, itching around nipples (temporary), an enlarged clitoris, hair loss, hair growth, changes in sex drive (normally an increase in sex drive), irritability, reduced testicle size, reduced sperm count and loss of fertility for males. There may be a need to monitor a CBC, blood pressure, review dose of blood thinners and thyroid dosing.

Advanced Beneficiary Notice (ABN)

________The services I am receiving today are not covered by my insurance. I agree to pay Montrose Wellness Center for services rendered at the time of service. I may request the appropriate insurance forms so that I can submit them to my insurance for possible reimbursement.

________I authorize and give consent to Montrose Wellness Center for the evaluation and treatment of my symptoms by the ordering of testing and administration of hormones. The goal and possible benefits of this therapy are to individually balance hormones for symptom management and possible optimization for chronic disease prevention. I am aware of the importance of my role in my symptom management and chronic disease management including knowing the importance of diet, exercise, stress management and healthy relationships. I understand this is not necessarily an FDA approved therapy. I certify that I will notify Montrose Wellness Center immediately of any possible symptoms, signs, or possible reactions to my therapy.

Patient Signature____Date_____________

Provider Signature_______________________________________ Date____________

NAME:______________________________ Today's Date:___________

Menopause Rating Scale (MRS)

Which of the following symptoms apply to you **at this time**?

MARK ONE Box For EACH Symptom

	None	mild	moderate	severe	extremely severe
Score =	0	1	2	3	4
Symptoms:					
1. Hot flashes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficult in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐
12. Breast tenderness	☐	☐	☐	☐	☐
13. Vaginal bleeding	☐	☐	☐	☐	☐
14. Migraines	☐	☐	☐	☐	☐
15. Voice changes	☐	☐	☐	☐	☐
16. Fluid Retention	☐	☐	☐	☐	☐
17. Facial hair	☐	☐	☐	☐	☐
18. Dry eye	☐	☐	☐	☐	☐

Baseline: ______No hormone therapy before

______Hormone therapy (circle): Patch Drop Cream SL tabs Implant Oral

History of breast cancer: personal__________ family__________

Follow up:Last hormone appointment: ______________________________

______Hormone replacement by (circle): Patch Drop Cream SL tabs Implant Oral Vaginal Cream

______Pellet implant therapy: Testosterone: ____________ Estrogen: _____________Weeks since implant____________

Pre-menopausal _________Post-menopausal _________Hysterectomy ___________Ovaries removed_____________

Females: Informed Consent for Insertion of Subcutaneous Pellet Implants

Testosterone (T) and estrogen (E) pellets have been used for hormone therapy in women since 1940. There is no FDA-approved T therapy for low testosterone in women. Oral Methyl T (synthetic) was approved by the FDA and previously used to treat breast cancer. T and other pellets may be compounded and used off-label in women. Pellets are placed under the skin of the lower abdomen or upper gluteal area as an outpatient office procedure under local anesthesia. Pellets completely dissolve and are not removed.

Possible risks of pellet therapy may include:

- Expulsion of pellet.
- Bleeding, bruising, scarring, infection and pain at the insertion site.
- Lack of effect (from lack of absorption) or need for dosage adjustment.
- Breast tenderness, swelling and itching around nipples especially in the first three weeks.
- Increase in hair growth on the face, groin, legs and arms; similar to pre-menopausal patterns.
- Possible hair loss. Scalp hair thinning occurs with age and hormone decline. However, some studies have shown an association between high testosterone levels and hair loss.
- Water retention (estrogen only).
- Increased growth of estrogen dependent tumors (endometrial cancer, breast cancer). Recent studies have suggested T pellet therapy may lower the risk for breast cancer.
- Birth defects in babies exposed to testosterone during their gestation.
- Blood clots/phlebitis.
- Change in voice (reversible).
- Clitoral enlargement (reversible).
- Acne.

Possible benefits of pellet therapy may include:

- Increased libido, energy and sense of well-being.
- Increase in muscle mass and decrease in subcutaneous fat (cellulite).
- Increase is bone density.
- Decreased frequency and severity of hormonal migraine headaches.
- Decrease in mood swings, anxiety & irritability.
- Decreased central obesity.
- Improved dry eyes.
- Improvement in arthritis and fibromyalgia.
- Improvement in insulin resistance and diabetes parameters.

Pellets deliver hormones for three to five months on average in females. T stimulates the bone marrow to produce red blood cells, which may elevate the red blood cell count (hematocrit). Serum (blood) T levels on pellet therapy are much higher than the "normal" range for females. Symptoms may return when serum levels approach twice the upper normal range for young females. Both T's effects and side effects are typically dose dependent.
Estrogen may be given along with testosterone as a vaginal cream, topical patch, implant or gel. Estrogen can stimulate the uterus lining and cause bleeding. ***Oral*** estrogens may increase the risk of blood clots or stroke. ***Oral*** androgens and other androgen formulations may adversely affect the liver, blood clots or lipid profile. Progesterone may be prescribed as an oral capsule. If you have a uterus or experience vaginal bleeding, you may be asked to get a pelvic ultrasound. Please notify Dr. Frazzetta prior to the procedure if you have a history of breast disease, abnormal uterine bleeding, fibroids, endometriosis, or have required a D&C or endometrial ablation in the past. It is recommended that you have an annual exam by your gynecologist or primary care provider.

Females: Informed Consent for Insertion of Subcutaneous Pellet Implants

T is the major substrate or "building block" for estrogen. Symptoms of excess estrogen include fluid retention, bloating, anxiety, irritability, breast pain or weight gain. Estrogen may stimulate a breast cancer. An estrogen blocker (aromatase inhibitor/ anastrozole) may be combined with T in the compounded implant. This is also off-
label use. Finasteride or spironolactone, which blocks the conversion of T to DHT, may also be used off-label in oral form to help manage hair issues.

- It is recommended that you have a normal breast exam and mammogram prior to therapy. It is your responsibility to notify Dr. Frazzetta about any breast changes or lumps prior to pellet insertion.
- You must notify Dr/ Frazzetta of any allergies or bleeding problems prior to the procedure including anti- coagulant (i.e. Coumadin, Plavix), ibuprofen, naproxen, or aspirin therapy.
- If applicable, you must notify your oncologist prior to having the T or T + anastrozole pellets placed.
- Implants or pellets are not removed.
- If you are **premenopausal,** you **must** use birth control. Theoretically, testosterone could masculinize a female fetus. Aromatase inhibitors are contraindicated in pregnancy: the possible adverse effects on a fetus are unknown. Please notify the office if you become pregnant.

I have read and understand the above information. My signature below certifies I have read the above and acknowledge I have been encouraged to ask any questions regarding testosterone and estrogen pellets. My questions have been answered to my satisfaction. I understand the procedure, benefits, risks, side effects and alternatives to the implantation of hormone pellets.
I understand that testosterone, estrogen, and testosterone-anastrozole pellets are not FDA approved in women. I understand that higher than normal physiologic levels of hormone may be reached to create the necessary hormonal balance. By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I consent to the insertion of hormone pellets. I have been informed that I may experience one or more of the complications listed above. These side effects are similar to those related to traditional estrogen replacement. The surgical risks are the same as for any minor medical procedure.

I agree to allow Gayle Frazzetta, MD to implant the pellets. I understand that Dr. Frazzetta will not be assuming my healthcare or gynecologic care, unless previously arranged. It is the patient's responsibility to continue to have regular follow up appointments with their primary care physician and/or gynecologist. My data may be used (anonymously) in a study or for research and may be included in publications. I am aware that Dr. Frazzetta does not accept health insurance for the insertion of pellets. For any hormone therapy that is not covered by health insurance, payment is due at the time of service. Forms are available upon request for self-submission to insurance. All questions and concerns have been addressed. **This consent is ongoing for this and all future pellet insertions.**

Patient Name:___________ Patient Signature:_____________________ Date:______________

Name________________________________DOB______________

Testosterone:_____Baseline:______ Follow up Peak/Trough______PSA______Date______Hgb_____Date____

MALE AMS Questionnaire

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark "none".

Symptoms:	none	mild	moderate	severe	extremely severe
Score=	1	2	3	4	5
1. **Decline in your feeling of general well-being** (general state of health, subjective feeling)............	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, pain in a limb, general back ache)..................	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flashes independent of strain)..........	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep, staying asleep, waking up early and feeling tired, poor sleep, sleepiness)................................	☐	☐	☐	☐	☐
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, reducing activity, lacking interest in activity, feeling of getting less done, of achieving less, of having to force oneself to undertake activities..	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling weak)............	☐	☐	☐	☐	☐
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-bottm**..................	☐	☐	☐	☐	☐
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)**..................	☐	☐	☐	☐	☐
18. **Fluid retention, weight gain**.................................	☐	☐	☐	☐	☐
19. **Breast pain, enlargement**..	☐	☐	☐	☐	☐
20. **Prostate problems, urinary problems**.......................	☐	☐	☐	☐	☐
21. **Memory loss, lack of concentration**..........................	☐	☐	☐	☐	☐

Have you got any other major symptoms? Yes........☐No........☐

If Yes, please describe____

Male: Informed Consent for Testosterone Therapy

Testosterone (T) pellet implantation has been used for androgen replacement since 1940. Implants may be manufactured (Testopel) or compounded. The pellets implants are placed under the skin and into the fat of the abdominal wall or upper gluteal area through a small incision using local anesthesia. Complications may occur and may include, but are not limited to, extrusion of the pellet, bleeding, bruising, pain, swelling, skin discoloration, scarring, acne and infection. An ice pack may be applied following the procedure. Pellets dissolve over time, usually every 5-6 months and are not removed. Testosterone may also be replaced using an injection every week or a daily gel.

The dose of T prescribed by Dr. Frazzetta may be higher than historical dosing. T does not cause prostate cancer but may **stimulate an undiagnosed prostate cancer**. If your PSA is elevated, you will need written approval from your urologist or a primary care physician prior to T therapy. T may also **increase the production of red blood cells**. If the red blood cell count elevates above normal, you may need to donate blood and/or lower your dose of T. Testosterone decreases sperm production and possibly decrease testicular size and may worsen sleep apnea. Additionally, men predisposed to hair loss may experience this as well. There is no "first pass effect", meaning it avoids the liver and does not increase clotting factors. A few recent studies have suggested an increased risk of cardiovascular events in men receiving T therapy, particularly in men with a history of heart disease. Other studies have shown a decreased risk of heart disease. In June 2014, the FDA issued a warning about the possibly of increased blood clots in veins. ***Oral*** androgens and other androgen formulations may adversely affect the liver or lipid profiles. Currently, the FDA has only approved treatment for men with T levels < 300, therefore your treatment may be used to treat symptoms of T insufficiency with blood levels higher than this. Data would support this approach.

T is the major substrate or building block for estrogen. Symptoms of excess estrogen include fluid retention, bloating, breast tenderness, irritability and weight gain. You may be treated "off-label" with an estrogen blocker/aromatase inhibitors (anastrozole), which can be combined with T in the compounded pellet implant or taken orally. Finasteride may also be used "off-label" to prevent the conversion of T to DHT which may contribute to male pattern hair loss. T and estrogen levels may be checked to assess the absorption of T and monitor the conversion to estrogen.

- You may elect a trial of T therapy with a short acting T preparation (e.g., gel, shot).
- PSA levels will be monitored 6 months after starting treatment and yearly thereafter.
- If your PSA increases on T therapy, you must see your doctor or urologist for a complete evaluation.
- You may resume therapy after a negative prostate biopsy or clearance from your physician/urologist.
- You must notify the physician of any allergies or bleeding problems prior to the procedure including anti-coagulant, NSAID, or aspirin therapy.
- You should avoid vigorous physical activity for 7 days following the insertion of the pellets.

Male: Informed Consent for Testosterone Therapy

I have read and understand the above information including the procedure, benefits, risks and alternatives to the implantation of T or T+ anastrozole pellets and T therapy. My signature below certifies I have read the above and acknowledge I have been encouraged to ask questions regarding therapy. All questions and concerns have been addressed and answered to my satisfaction. I agree to allow Dr. Gayle Frazzetta to implant the pellets or begin treatment with gel or injectable. By beginning treatment, I accept all risks of therapy and future risks that might be reported.

I understand that Dr. Frazzetta will not be assuming my healthcare unless previously arranged. I am aware that Dr. Frazzetta does not accept health insurance for pellet implant procedures. For any hormone therapy that is not covered by health insurance, payment is due at the time of service. Forms are available upon request for self-admission to insurance. I have discussed any questions or concerns with Dr. Frazzetta. I agree to follow up with my primary care physician for my medical care, annual physical exams and prostate exam as indicated. I understand and agree that my data including lab results may be used anonymously for research purposes and publication. **This consent is ongoing for this and all other future pellet insertions.**

Patient Name:____________________Patient Signature: ______________________ Date:_______