SUMMIT MEDICAL CARE CENTER, L.L.C.
ABOVE AND BEYOND WELLNESS

bioTE MEDICAL

Living Well
Nutrition Solutions for Life

Male Patient Questionnaire & History

Name:_____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ Weight: _____ Height:_____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip: _____

Best Contact Number:_____ Alternate #: _____

E-Mail Address:_____

In Case of Emergency Contact:_____ Relationship: _____

Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Number of children: _____

Please list your TOP 3 unwanted symptoms/health concerns:

1._____

2._____

3._____

Please circle the services (as many as apply) you are interested in hearing about at our clinic:

Weight Loss Nutrition Hormone Balance/BioTE Pain/Inflammation Reduction

Stress Support Digestive Support Lab Work / Food Sensitivity Testing Red Light Therapy

Allergy Elimination with Laser Neurofeedback Chiropractic Massage therapy

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Health Intake

Nutritional/Vitamin Supplements: _____

_____

_____

Digestion/Elimination: Check any: ( ) I have a normal bowel movement daily ( ) I have two or more BMs daily
( ) I don't eliminate every day ( ) I have less than 2 BMs weekly ( ) I eliminate daily, but loose/watery
( ) I use laxatives ( ) I have heartburn / acid reflux / GERD ( ) I experience gas /discomfort/bloating
( ) I have/had hemorrhoids

Weight/Body Composition: Check one: ( ) I am content with my body and weight currently
( ) I want to lose ____ lbs. ( ) I want to gain ____ lbs. ( ) I am using or have used methods to control my weight

Physical Activity: ___ Low/Sedentary (spend more time sitting/driving than walking/exercising)
___ Moderate (average mix of exercise/activity) ___ Active (work out 5-7 days weekly for 30 min. or more)
Exercise routine if applicable _____

Daily Habits: Check any/all that apply:
( ) I eat only when I'm hungry ( ) I eat 3-5 small meals daily ( ) I skip meals unintentionally
( ) I over eat unconsciously ( ) I don't really think about eating; it just happens ( ) No matter how much I eat I am never full ( ) I eat foods I know don't agree with me/knowing I'll feel uncomfortable after eating them
( ) I eat when I'm sad or stressed or anxious ( ) I eat secretly ( ) I want to improve my eating habits
( ) I drink regular soda ____ daily ____ weekly ____ rarely ____ never
( ) I drink diet soda ____ daily ____ weekly ____ rarely ____ never
( ) I drink energy drinks (i.e., red bull, celsius, monster) ___ daily ___ weekly ___ rarely ___ never
( ) I drink coffee ___ cups daily ( ) I don't drink coffee ( ) I smoke or use nicotine ___ yes ___ no
( ) I drink alcoholic beverages ___ number of drinks weekly ___ I only drink socially/rarely
( ) I choose not to drink alcohol ( ) I am a recovering alcoholic (sober since ____)
( ) I drink water: ____ less than 3 cups (24 oz) daily ____ 3—7 cups daily ____ 8 cups + daily
( ) I use THC ___ yes ___ no If yes, what form and how much (daily, weekly…) _____
( ) I drink or use dairy (milk, skim milk, yogurt, cheese, butter, creams, ice cream) ____ yes ____no
( ) I crave: ____salty foods ____ sweets ____ bread/pasta/beer ____caffeine ____ alcohol ____ dairy

Known or Suspected Allergies or Food Sensitivities: _____
( ) I have been diagnosed with or suspect yeast overgrowth/candida ( ) I battle sinus/allergy or asthma

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes, please explain: _____

Medications with dosing: _____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Surgeries, list all and when: _____

I have completed my family ___ yes ____no

Other Pertinent Information: _____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone 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 completely 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.

_____ _____ _____
Print Name **Signature** **Today's Date**

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____ Year: _____
( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

_____ _____

Name: _____ _____

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				
Bladder/Bowel Incontinence				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/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				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are 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 plant derived 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, pain, reaction to local anesthetic and/or preservatives, lack of effect (typically from lack of absorption), thinning hair, male pattern baldness, increased growth of prostate and prostate tumors, extrusion of pellets, hyper sexuality (overactive libido), ten to fifteen percent shrinkage in testicle size and 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; and 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** **Date**

Informed Consent for Nutritional Services and/or Purchases of Goods/Services

Living Well, LLC, Amy Richardson, Certified Nutrition Therapist (CNT) is not a medical professional. I understand that Living Well, LLC, Amy Richardson, (CNT) does not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent as so doing. The services of a Nutrition Professional cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not, to assist you in your care is your right and Living Well, LLC, Amy Richardson, (CNT) assumes no responsibility for your decision in this matter. By signing below, you are stating that you have informed Living Well of all your known physical conditions, medical conditions, and medications, and will keep them informed of any changes.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Living Well, LLC, Amy Richardson, (CNT) as I so choose. I hereby release Living Well, LLC, Amy Richardson, (CNT) from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Living Well, LLC, Amy Richardson, (CNT) and participate in a professional relationship with them pursuant to the statements herein.

Client's Name (print) Client's Signature Date

If Minor, Client's Representative (print) Signature of Client's Rep. Relation to Client Date