

# MALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)					
Sleep Problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)					
Decline in drive or interest (loss of "zest for life," feeling down or sad)					
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Sexual Desire or Performance (reduced or diminished)					
Erectile changes (weaker erections, loss of morning erections)					
Ejaculations (infrequent or absent)					
Sweating (night sweats or increased episodes of sweating)					
Hair loss, rapid or thinning					
Feeling cold all the time, having cold hands or feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty in urinating, increased need to urinate)					

Other symptoms or unique health circumstances to take into consideration:

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\_\_\_\_\_

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\_\_\_\_\_

# MALE HEALTH HISTORY & SYMPTOMS

## For CDSS Round 1

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

### PATIENT QUESTIONS

Currently trying to conceive?	Yes	No
Are you on a 5-alpha reductase inhibitor?	Yes	No
Are you on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)	Yes	No
Are you on any other testosterone boosting medication (Clomid, HCG, etc.)?	Yes	No
Are you currently utilizing BHRT or HRT?	Yes	No
If yes, select types of Hormones:	Testosterone	Thyroid
List name and dose of hormone(s): _____		
Are you currently on statins?	Yes	No
Are you a smoker?	Yes	No
Are you currently on oral nitrates?	Yes	No

### MEDICAL HISTORY

#### Select all that apply:

#### Fertility:

Want to Maintain Fertility

#### Cardiovascular Conditions:

Heart Attack or Stroke (within last 6 months)

Tachycardia

DVT or Blood Clot (within last 6 months)

Hypertension

Hyperlipidemia

Obstructive Sleep Apnea

Patient Takes Anticoagulant Medication

Atrial Fibrillation

#### Cancer:

Breast Cancer or History of Breast Cancer

Active Prostate Cancer or History of Prostate Cancer

Thyroid Cancer or History of Thyroid Cancer

Except for Basal Cell Carcinoma, Any Other Cancers?

#### Neurological Conditions:

Epilepsy or Seizure Disorder

Depression/Anxiety

Psychiatric Conditions

Migraine with Aura

Meningioma

#### Endocrine and Metabolic:

Diabetes Type 2 or Insulin Resistance

Hyperthyroid

Hypothyroid

Multiple Endocrine Neoplasia Type-2

# MALE HEALTH HISTORY & SYMPTOMS

## For CDSS Round 1

### MEDICAL HISTORY

#### Autoimmune Conditions:

- Diabetes Type 1
- Hashimoto's Thyroiditis
- Graves' Disease
- Rheumatoid Arthritis
- Multiple Sclerosis
- Systemic Lupus (Erythematosus)
- Psoriasis
- IBS (Irritable Bowel Syndrome)
- Crohn's Disease
- Ulcerative Colitis

#### Organ Specific Conditions:

- Liver Disease or History of Liver Disease
- Kidney Disease or History of Kidney Disease
- LAM (Lymphangiomyomatosis)
- Osteoporosis or Osteopenia
- Prostate Enlargement (BPH)
- HIV
- Hepatitis
- Hemochromatosis
- Pancreatitis or History of Pancreatitis
- History of or Gall Bladder Disease
- Polycythemia Vera (PV)

### SYMPTOMS AND CONCERNS

#### Select all that apply:

- Acne
- Erectile Dysfunction (ED)
- Decreased Libido
- Decreased Desire
- Inability To or Delayed Orgasm
- Weight Gain
- Decreased Muscle Mass
- Difficulty Sleeping
- Urinary Incontinence
- Dry or Flaking Skin
- Lack of Energy (Fatigue)
- Decrease in Strength or Endurance
- Decrease in Work Performance
- Frequent Urinary Tract Infection
- Brittle Nails
- Thinning Eyebrows
- Hair Thinning
- Cold Hands or Feet
- Mind Racing at Bedtime
- Eating When Stressed
- Mood Swings
- Gynecomastia
- Abdominal Obesity

# MALE HEALTH HISTORY & SYMPTOMS

## For CDSS Round 2

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

### PATIENT QUESTIONS

Have you been diagnosed with any cancer since initial pelleting (excluding basal cell carcinoma)?	Yes	No
Blood clot, DVT, heart attack or stroke since being pelleted?	Yes	No
Currently trying to conceive?	Yes	No
Are you on a 5-alpha reductase inhibitor?	Yes	No
Are you on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)	Yes	No
Select types of hormones you are currently on.	Testosterone	Thyroid
Are you on any other testosterone boosting medication (Clomid, HCG, etc.)?	Yes	No
Are you currently on statins?	Yes	No
Are you a smoker?	Yes	No

### PATIENT'S CURRENT AND PAST MEDICAL HISTORY

#### Select all that apply:

#### Fertility:

Want to Maintain Fertility

#### Cardiovascular Conditions:

Tachycardia

Hypertension

Hyperlipidemia

Obstructive Sleep Apnea

Atrial Fibrillation

#### Neurological Conditions:

Epilepsy or Seizure Disorder

Depression/Anxiety

Psychiatric Conditions

Migraine with Aura

Meningioma

#### Endocrine and Metabolic:

Diabetes Type 2 or Insulin Resistance

Hyperthyroid

Hypothyroid

# MALE HEALTH HISTORY & SYMPTOMS

## For CDSS Round 2

### MEDICAL HISTORY

#### Autoimmune Conditions:

Diabetes Type 1  
Hashimoto's Thyroiditis  
Graves' Disease  
Rheumatoid Arthritis  
Multiple Sclerosis  
Systemic Lupus (Erythematosus)  
Psoriasis  
IBS (Irritable Bowel Syndrome)  
Crohn's Disease  
Ulcerative Colitis

#### Organ Specific Conditions:

Liver Disease (since last pellet)  
Kidney Disease (since last pellet)  
LAM (Lymphangiomyomatosis)  
Osteoporosis or Osteopenia  
Prostate Enlargement (BPH)  
HIV  
Hepatitis  
Hemochromatosis  
Pancreatitis (since last pellet)  
History of or Gall Bladder Disease  
Polycythemia Vera (PV)

### PATIENT'S SYMPTOMS

#### Select all that apply:

Acne  
Erectile Dysfunction (ED)  
Decreased Libido  
Decreased Desire  
Inability To or Delayed Orgasm  
Weight Gain  
Decreased Muscle Mass  
Difficulty Sleeping  
Urinary Incontinence  
Dry or Flaking Skin  
Lack of Energy (Fatigue)  
Decrease in Strength or Endurance  
Decrease in Work Performance  
Frequent Urinary Tract Infection  
Brittle Nails  
Thinning Eyebrows  
Hair Thinning  
Cold Hands or Feet  
Mind Racing at Bedtime  
Eating When Stressed  
Mood Swings  
Gynecomastia  
Abdominal Obesity

# Male Hormone Replacement Insertion Consent

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

My physician/practitioner has recommended testosterone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low testosterone levels. The following information has been explained to me prior to receiving the recommended testosterone therapy.

## OVERVIEW

Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

## RISKS/COMPLICATIONS

Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion, which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications: acne, anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or male pattern baldness, increased growth of prostate and prostate tumors, which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, which may lead to permanent infertility, and increased hematocrit. The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Elevated HCT, which is dose and serum testosterone level dependent, may lead to increased clotting.

All types of testosterone replacement can cause a significant decrease in sperm count during use. If you are planning to start or expand your family, please talk to your provider about other non-testosterone options.

It is advisable that all males > 40 years old who are on testosterone therapy should have a PSA checked at least yearly.

## CONSENT FOR TREATMENT

I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits. I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered.

Blood tests may be necessary on several occasions during the 1st year to help with dosing, and then annually or biannually at the discretion of the prescribing practitioner.

I understand that my blood tests may reveal that my levels are not optimal, which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets. I have read or have had this form read to me.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

## I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INFORMATION ON THIS FORM

### PATIENT:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### WITNESS:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Male Post-Insertion Instructions

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip, and the outer layer is a waterproof dressing.
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks. If the redness worsens after the first 2-3 days, please contact the office.
- Your clinician has advised you to not take tub baths or get into a hot tub or swimming pool for 7 days. You may shower, but do not remove the bandage or steri-strips for 7 days.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- For flank insertion: Your clinician has advised against using the affected area in activities such as rowing, golfing, lower back exercises, abdominal twists. Ok to use lower glute and leg muscles and upper body.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness contact your clinician for further instructions.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding (not oozing) not relieved with pressure, as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.
- Please call if the area becomes red and warm to the touch.
- We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

## REMINDERS

- Remember to have your post-insertion blood work 1-2 weeks prior to your next insertion and as outlined by your health care provider.
- Most men will need re-insertion of their pellets 4-5 months after their initial insertion. If you experience symptoms prior to this, please call the office.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

## ADDITIONAL INSTRUCTIONS

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**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INFORMATION ON THIS FORM.**

### PATIENT:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### WITNESS:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# What Might Occur After a Pellet Insertion for Males

A significant hormonal transition may occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

## INFECTION

Infection is a possibility with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

## ELEVATED RED BLOOD CELL COUNT

Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased. Routine blood donation may be helpful in preventing this.

## PELLET EXTRUSION

Pellet extrusion is uncommon and occurs in < 5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

## ITCHING OR REDNESS

Itching or redness in the area of the incision and pellet placement is common. Some patients may also have a reaction to the tape or glue. If this occurs, apply hydrocortisone to the area 2-3 times daily. If the redness becomes firm or starts to spread, please contact the office.

## FLUID RETENTION/WEIGHT GAIN

Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds.

## SWELLING OF THE HANDS & FEET

This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.

## BREAST TENDERNESS OR NIPPLE SENSITIVITY

These may develop. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Take 2 DIM daily to support healthy estrogen metabolism. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). DIM supports healthy estrogen metabolism. Testosterone normally converts to estradiol, and high estradiol levels in males may lead to breast and nipple tenderness, as well as sexual dysfunction.

## MOOD SWINGS/IRRITABILITY

These may occur if you were quite deficient in hormones. These symptoms usually improve when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

## HAIR LOSS OR ANXIETY

Usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. 5HTP may be helpful for anxiety and is available over-the-counter.

## FACIAL/BODY BREAKOUT

Acne may occur when testosterone levels are either very low or high. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

## AROMATIZATION

Some men will form higher-than-expected levels of estrogen from the testosterone. Symptoms such as nipple tenderness or feeling emotional may be observed.

## HIGH OR LOW HORMONE LEVELS

The majority of times, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a "boost" (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.

## TESTICULAR SHRINKAGE

Testicular shrinkage is expected with any type of testosterone treatment.

## LOW SPERM COUNT

Any testosterone replacement will cause significant decrease in sperm count during use. Pellet therapy may effect sperm count, which may lead to permanent infertility. If you are planning to start or expand your family, please talk to your provider about other options.

## I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INFORMATION ON THIS FORM

### PATIENT:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### WITNESS:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_