MALE NEW PATIENT PACKAGE

QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

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

Home address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

May we contact you via text and email? ☐ Yes ☐ No

How did you hear about us? Client/Employee Name: _____

Facebook____ Instagram____ Twitter____ Yelp____ Google____ Walk-In____ Other_____

In case of emergency Contact: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

Primary Care Physician's Name: _____ Office Phone: _____

Address: _____
Address/City/State/Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. OR ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm, or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars _____ per day. ☐ I use e-cigarettes _____ per day.

☐ I use caffeine _____ a day. ☐ I drink alcoholic beverages _____ per week.

☐ I drink more than 10 alcoholic beverages a week.

MALE NEW PATIENT PACKAGE

QUESTIONNAIRE & HISTORY CONTINUED

Drug Allergies:

Drug allergies: _____If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other _____

Pertinent medical/surgical history:

☐ Cancer (type & year) _____
☐ Elevated PSA
☐ Trouble passing urine
☐ Taking medicine for prostate or male-pattern balding
☐ History of anemia
☐ Vasectomy
☐ Erectile dysfunction
☐ Taking medicine for high cholesterol
☐ Testicular or prostate cancer
☐ Prostate enlargement or BPH
☐ Kidney disease or decreased kidney function
☐ Frequent blood donations
☐ Non-cancerous testicular or prostate surgery
☐ Severe snoring

Birth control method:

☐ Not applicable
☐ None- planning pregnancy in the next year
☐ Depend on partner's contraception
☐ Vasectomy
☐ Condoms
☐ Other: _____

Medical history:

☐ High blood pressure or hypertension
☐ Heart disease
☐ Atrial fibrillation or other arrhythmia
☐ Blood clot and/or a pulmonary embolism
☐ Depression/anxiety
☐ Chronic liver disease(hepatitis, fatty liver, cirrhosis)
☐ Arthritis
☐ Hair thinning
☐ High cholesterol
☐ Stroke and/or heart attack
☐ HIV or any type of hepatitis
☐ Hemochromatosis
☐ Psychiatric disorder
☐ Thyroid disease
☐ Diabetes
☐ Lupus or other autoimmune disease
☐ Sleep apnea
☐ Other _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
• Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
• Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
• Sleep problems (difficulty falling asleep, sleeping through the night, or waking up too early)	☐	☐	☐	☐	☐
• Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
• Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
• Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
• Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation)	☐	☐	☐	☐	☐
• Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
• Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
• Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
• Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
• Difficulties with memory	☐	☐	☐	☐	☐
• Problems with thinking, concentrating, or reasoning	☐	☐	☐	☐	☐
• Difficulty learning new things	☐	☐	☐	☐	☐
• Trouble thinking of the right word to describe persons, places, or things when speaking	☐	☐	☐	☐	☐
• Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
• Rapid hair loss or thinning	☐	☐	☐	☐	☐
• Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
• Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
• Infrequent or absent ejaculations	☐	☐	☐	☐	☐

Total Score: _____

Severity score: Mild 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine).
Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient office visit fee ---------- $150
Male hormone pellet insertion fee ----------$725
4-week follow-up labs ----------$125
New patient labs ----------$225

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, Care Credit, FSA/HSA, and Cash

Print name: _____

Signature:_____Date: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND/OR READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name: _____

Signature: _____ Date: _____

INFORMED CONSENT

This document is a binding agreement (the "Agreement") between Emerge Integrative Medicine ("Amy Oden, APRN, FNP-C, ABAAHP") and the individual patient whose name and signature appears below ("You" "I"). In consideration of the health care services which may be provided to you by Amy Oden, APRN, FNP-C, ABAAHP at the present and always in the future. You agree as follows (your agreement indicated by placing your initials on the lines following each section and by signing in the space provided):

1. **Consent for Treatment.** I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risk of injury or death. I hereby consent to authorize Amy Oden, APRN, FNP-C, ABAAHP to provide you with health care treatments which, depending on your health conditions, may include one or more of the following procedures: Integrative Medicine, Intravenous Infusions, Intramuscular Injections, Hormonal Replacement Therapy, Herbal Medicine, Threads, Dietary and Nutritional Consultation, Platelet Rich Plasma Injections; together the "Treatments" administered by Amy Oden, APRN, FNP-C, ABAAHP or her staff. **Initials** ____
2. **Insurance Coverage.** I acknowledge that Amy Oden, APRN, FNP-C, ABAAHP has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed treatments. I also understand that many insurance plans have clauses that limit coverage to "usual-and-customary fees for reasonable and necessary services". I realize that some treatment of the integrative medical services provided by Amy Oden, APRN, FNP-C, ABAAHP will not fall under this description, and I do not hold her responsible for the possible decision by an insurance company that services provide to me are not covered under a specific insurance contract. **Initials** ____
3. **Experimental Nature of Treatments.** I acknowledge and agree that the treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. I acknowledge that the safety and efficacy record of some of the Treatments appear to be relatively safe and effective. Amy Oden, APRN, FNP-C, ABAAHP has informed you that the treatments may alter, address, or decrease your symptoms or complaints, but also may have no effect. You are consulting with Amy Oden, APRN, FNP-C, ABAAHP solely for reasons concerning your health. You are not consulting Amy Oden, APRN, FNP-C, ABAAHP to provide any information to any enforcement, regulatory, or investigative agency of any kind. **Initials** _____
4. **Intravenous Therapy, Injection Therapy Risks, Side Effects, Complications.** Amy Oden, APRN, FNP-C, ABAAHP hereby inform you that there are certain unavoidable risks and potential side effects and complications to the treatments, including without limitation, swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, metabolic disturbances. Treatments may very rarely cause infection or injury to nerves. **Initial** _____
5. **Description of Treatments.** The exact procedure, as well as the recommended sequence of treatments, will be explained to you when Amy Oden, APRN, FNP-C, ABAAHP or her nurse who administers the treatments. I acknowledge that any of the treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicine, and FDA approved prescriptive medicines, local anesthetic (i.e., Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma) and, on occasion, other substances which will be explained to you before injections. **Initials** _____
6. **Information You Provide Emerge Integrative Medicine.** I have provided Emerge Integrative Medicine with a complete list of all prescription and non-prescription medications (i.e., dietary supplements) you are currently taking. Also, I will provide a complete list of all known allergies you may have and all allergic reactions you have had in the past to any medicines, dietary supplements, or medical treatments of any kind. I agree to update Emerge Integrative Medicine immediately should this list change. **Initials** _____

By my signature below, I certify that I have read and understand the above.

Signature of Patient: _____ Date: _____

Emerge Integrative Medicine

Dr. Ladd Atkins, D.O. Amy Oden, MSN, APRN, FNP-C, ABAAHP

Missed Appointment/Cancellation Policy

We understand the need to move or cancel an appointment, however, to protect our providers and be courteous to patients on our waiting list, we ask you cancel or reschedule within 24 hours or a $130 fee will occur. This applies to appointments that are missed without notice. Your time is valuable as is ours, and we continually strive to serve you better. Please note if you arrive for your appointment 15 minutes beyond scheduled start time, we are required to reschedule your appointment. Cancellation fees will apply. **Call or text 918-922-9122.**

Returned Check Policy

It is Emerge policy on returned checks to charge a fee of $45 plus the amount of the check. This fee must be paid in cash or with credit card within 7 days. If we do not receive the payment in our office within 7 business days, the check will be sent to Tulsa County District Attorney. **We do not accept checks over $250**.

Refund Policy

Products may be returned within 2 weeks of purchase (restrictions may apply) along with the original receipt to receive a Emerge Integrative Medicine Account Credit. This credit will be applied to use towards a future purchase. All sales are final on services.

I attest the above statements to be true, my treatment provider and Emerge relies on the information I provided for safe and effective treatment.

Signature: _____ Date: _____

Photo and Video Consent and Authorization

I _____ do hereby consent and authorize to the following. I am allowing Emerge and/or delegated photographer to take photos and videos of my treatment and/or treated areas to be used for the purpose of monitoring my progress. I give permission for my photos and/or videos to be used at all Emerge locations for educational, advertising, and social media purposes within the Emerge brand.

Print Name: _____

Signature: _____ Date: _____

PELLET INSERTION CONSENT FOR MALES

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 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 hormones. 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, 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, increase in neck circumference, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter. If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

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. I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

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 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 have read or have had this form read to me.

Signature: _____ Date: _____

Print Name: _____ Date: _____

MALE TREATMENT PLAN

- The following medications or supplements are recommended in addition to your pellet therapy.
- It is best to take these vitamins and/or supplements after eating.
- **If you are currently using another form of testosterone, please stop after 7 to 10 days.**

SUPPLEMENTS: **These are available in our office for your convenience. For best results, please take the supplements recommended for you. Take all supplements or vitamins AFTER a meal.**

_____ ADK 5 or _____ ADK 10 - take 1 daily or as directed.

_____ Arterosil - take 1 capsule twice daily; take 1 capsule 3x daily if taking for diabetic neuropathy.

_____ BPC-157 - take 2 capsules per day with water or as directed.

_____ Bacillus Coagulans - take 1 daily or as directed.

_____ Curcumin SF - take 1-2 twice daily.

_____ DIM SGS+ - take 2 daily. 1 in AM and 1 in PM.

_____ Deep Sleep - take 2 capsules 30 minutes before bed or as directed.

_____ Iodine+ - start by taking 2-3x weekly and gradually increase to daily dosing; start Iodine+ about 4 weeks after your first round of pellets.

_____ Methyl Factors+ - take 1 daily or as directed based on B12 or other lab results.

_____ Multi-Strain Probiotic 20B - take 1 to 2 weekly then increase after 1 month to 1 daily.

_____ Omega 3 + CoQ10 - take 1-2 twice daily.

_____ Senolytic Complex - take 1 capsule per day with water or as directed.

_____ Serene - take 1 or 2 capsules with water as needed. Effects typically start to diminish after 3-4 hours. Dosing may vary.

_____ Other _____

PRESCRIPTIONS: **These have been called into your preferred pharmacy**

_____ NP Thyroid_____mg every morning on an empty stomach; wait 30 minutes before putting anything else on your stomach including coffee, food, or other medications.

_____ Wean off Synthroid/Levothyroxine: alternate your desiccated thyroid (NP Thyroid) every other day with Synthroid/Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ Femara (letrozole) 2.5 mg _____tablet every_____week(s).

_____ Arimidex (anastrazole) 1 mg_____tablet every _____ week(s).

_____Wean off your antidepressant (see wean protocol) once you are feeling better in 4-6 weeks.

_____Other _____

Please call or email for any questions about these recommendations.

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

Print name: _____ Date:_____

Signature: _____

MALE NEW PATIENT PACKAGE

POST-INSERTION INSTRUCTIONS FOR MEN

- 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.
- Do 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.
- No heavy lifting or major exercises for the incision area for the next 7 days, which includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surgace
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (50 mg orally every 6 hours). Caution: this can cause drowsiness!
- 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.
- 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 relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

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 done 4 weeks after your FIRST insertion.
- 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:

_____

_____

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

Print Name: _____

Signature: _____ Date: _____

MALE NEW PATIENT PACKAGE

WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE)

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

- INFECTION:
  Is possible 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.

- 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. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to 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. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- 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 with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Taking 2 capsules of DIM SGS+ daily helps prevent excess estrogen formation. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). This is usually prevented if DIM is taken regularly but can be easily treated and will be addressed further when your labs are done, if needed.

- MOOD SWINGS/IRRITABILITY/ANXIETY:
  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.

- ELEVATED RED BLOOD CELL COUNT:
  Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis 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.

- HAIR LOSS
  Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

- FACIAL/BODY BREAKOUT:
  Some pimples may arise if the testosterone levels are either too low or rise rapidly. 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 possible prescriptions.

- AROMATIZATION:
  Some men will form higher-than-expected levels of estrogen from the testosterone. Using DIM SGS+ 2 capsules daily as directed may prevent this. Symptoms such as nipple tenderness or feeling emotional may be observed. These will usually resolve by taking DIM, but a prescription may be needed.

- 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 affect sperm count up to one year. 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/OR UNDERSTAND AND READ THE INSTRUCTIONS ON THIS FORM.

Print Name: _____

Signature: _____ Date: _____