Gwinnett's
Progressive Healthcare
for Women

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We are pleased that you are interested in hormone optimization. In order to determine if you are a candidate, we will need laboratory information and information regarding your medical history. The content of this package is your first step in restoring your vitality. Please take time to read the information provided and complete the questionnaire and history forms.

Pellet Insertion: The use of formulated hormone replacement through BioTe® is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurse practitioners are board certified, insurance does not recognize this form of hormone replacement as necessary medicine BUT rather more like plastic surgery or aesthetic medicine. Therefore, pellet insertion is not covered by your insurance and will be charged at a rate of $350.00 per insertion. Patients usually receive 3-4 insertions each year.

Office Visits: Insurance companies are not obligated to pay for our services. We will bill your insurance for office visits. However, we make no guarantee that your insurance will cover these services. If your insurance is billed you will be responsible for all copays, deductibles, and coinsurance. If your insurance does not pay for these services, you will be responsible for any non-covered charges. The initial consult visit will be $200.00 and each subsequent visit is $50.00.

Labs: We have negotiated a cash price of $150.00 for labs. This price includes your pre-pellet labs and post pellet labs. It does not include any other labs that are required in your management (i.e., additional thyroid testing, labs done after one year). We can bill your insurance for these labs but we will be unable to negotiate with the lab company if you choose to have labs billed through your insurance and your insurance does not cover the charges. Keep in mind that you will be responsible for copays, deductibles, coinsurance. Labcorp and Propath are the lab companies that we use in our office.

For patients who have access to a Health Savings Account, you may pay for your treatment with that credit or debit card. It is your responsibility to request the receipt and paperwork to submit for your reimbursement.

Progressive Healthcare for Women

Address and Contact Information

Name: _____ Date of birth: _____

FEMALE 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)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, 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, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

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

Progressive Healthcare

Address and Contact Information

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

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

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ 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

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: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active.	OR	☐ I want to be sexually active.	☐ 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____ a day. ☐ I use caffeine____ a day.

☐ I drink alcoholic beverages____ per week. ☐ I drink more than 10 alcoholic beverages a week.

Progressive Healthcare for Women

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FEMALE PATIENT 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:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

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
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

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WHAT MIGHT OCCUR AFTER A PELLET INSERTION (FEMALE)

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 SWELLING:
  This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is Iodine+ if this occurs.
- MOOD SWINGS/IRRITABILITY/ANXIETY:
  These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- ELEVATED RED CELL COUNT (most common in men):
  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.
- 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. Workup for other causes may also be needed.
- FACIAL 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 possibly prescriptions.
- UTERINE SPOTTING/BLEEDING/ IRREGULAR PERIODS:
  This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem.
- HAIR GROWTH:
  Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or "peach fuzz" often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

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

Print name: _____

Signature: _____ Date: _____

Gwinnett Progressive Healthcare for Women

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PELLET INSERTION CONSENT FOR FEMALES

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

OVERVIEW
Bioidentical hormones are hormones that are biologically identical to that made in my own body. The levels of active estradiol and/or 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 estradiol and/or testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of estradiol and testosterone replacement available, and different methods can be used to deliver the therapy. There are no commercially available forms of testosterone, however, that are formulated specifically for use in women. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

PELLET ACTIVE INGREDIENTS
I understand that (please initial by the appropriate statement):

_____ I am receiving pellets today that contain testosterone only.

_____ I am receiving pellets today that contain estradiol and testosterone.

_____ I am receiving pellets today that contain testosterone and anastrozole.

RISKS/COMPLICATIONS OF TESTOSTERONE
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 with testosterone: acne, abnormal bleeding or a change in menstrual cycle (if patient has a uterus), 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 female pattern baldness, hypersexuality (overactive libido) or decreased libido, 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.

If you are planning to start or expand your family soon, please talk to your provider about other options.

RISKS/COMPLICATIONS OF ESTRADIOL (ONLY APPLICABLE IF RECEIVING ESTRADIOL IN THE PELLETS)
The side-effects of estradiol are similar to those listed above for testosterone. Additionally, there is some risk, even when using bioidentical hormones, that estrogens may cause existing cases of some breast cancers to grow more rapidly. This risk may also apply to some undiagnosed forms of breast cancer.

Using estrogen-alone (without progesterone) may increase the chance of getting cancer of the uterus. Endometrial sampling (biopsy) or surgery may be required if abnormal bleeding occurs.

Please initial if you are postmenopausal, have a uterus, and are getting estradiol.

_____ I understand that I have a uterus and am receiving postmenopausal dosing of estradiol. I agree to take progesterone as directed by my health care provider while receiving estradiol.

RISKS/COMPLICATIONS OF ANASTROZOLE (ONLY APPLICABLE IF RECEIVING ANASTROZOLE IN THE PELLETS)
Anastrozole is a type of medication called an aromatase inhibitor. Aromatase inhibitors limit or prevent the conversion of testosterone into estrogen. Aromatase inhibitors can be used for a variety of conditions but are most commonly used in patients with a history of estrogen receptor positive breast cancer.

Anastrozole should not be used in pregnant women and should be used with caution in women with pre-existing ischemic heart disease. Anastrozole in pellets should not be given to premenopausal women nor to women taking oral aromatase inhibitors (anastrozole or letrozole) or selective estrogen receptor modulators (tamoxifen or raloxifene).

The amount of anastrozole used in pellets is very low. The most common side-effects for women taking anastrozole are hot flashes, joint pain, and muscle pain. Because of the low dose in the pellet, these effects are not usually seen with this type of therapy, however.

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.

Witness name: _____ Signature: _____ Date: _____

Print name: _____ Signature: _____ Date: _____

Progressive Healthcare

Address and Contact Information

Name: _____ Date of birth: _____

POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It must be removed as soon as it gets wet. The inner layer (usually a steri strip) should be removed in 3 days.
- **Do not take tub baths or get into a hot tub or swimming pool for 3-4 days.** You may shower, but do not remove the bandage or steri-strips for 4 days.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, elliptical, squats, lunges, etc.
- 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 (25 to 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 6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.
- Most women will need re-insertion of their pellets 3-4 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: _____