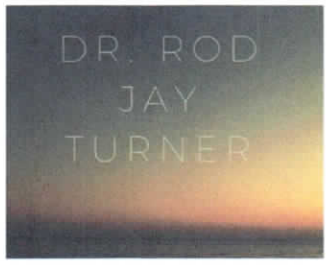


# FEMALE PATIENT QUESTIONNAIRE & HISTORY

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

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

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

E-Mail Address:_____ May we contact you via E-Mail? ( ) 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 mean's you've 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.

Spouse's Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work:_____

**Social:**
( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

**Habits:**
( ) I smoke cigarettes or cigars _____ per day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____a day.

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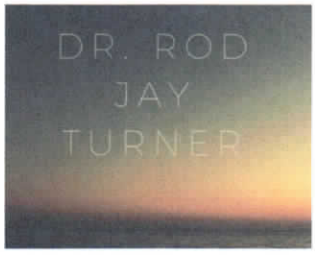


# MEDICAL HISTORY

Any known drug allergies:_____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes, please explain:_____

Medications Currently Taking:_____

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy:_____

Nutritional/Vitamin Supplements:_____

Surgeries, list all and when:_____

Last menstrual period (estimate year if unknown):_____

Other Pertinent Information:_____

**Preventative Medical Care:**

( ) Medical/GYN exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

**High Risk Past Medical/Surgical History:**

( ) Breast cancer.
( ) Uterine cancer.
( ) Ovarian cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy removal of ovaries.

**Birth Control Method:**

( ) Menopause.
( ) Hysterectomy.
( ) Tubal ligation.
( ) Birth control pills.
( ) Vasectomy.
( ) Other:_____

**Medical Illnesses:**

( ) Polycystic Ovary Syndrome(PCOS)
( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric disorder.
( ) Cancer (type):_____
Year: _____

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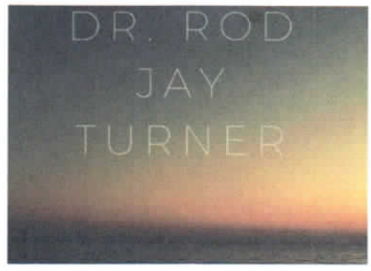


# Commonly Asked Questions

**Q. What is BioTE®?**
A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance to youthful levels in men and women.

**Q. How do I know if I'm a candidate for pellets?**
A. Symptoms may vary widely from depression and anxiety to night sweats and sleeplessness for example. You will be given a lab slip to have blood work done which will determine your hormone levels. Once the doctor reviews and determines you are a candidate we will schedule an appointment for insertion.

**Q. Do I have blood work done before each Treatment?**
A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

**Q. What are the pellets made from?**
A. They are made from wild yams and soy. Wild yams and soy have the highest concentration of hormones of any substance. There are no known allergens associated with wild yams and soy, because once the hormone is made it is no longer yam or soy.

**Q. How long will the treatment last?**
A. Every 3-6 months depending on the person. Everyone is different so it depends on how you feel and what the doctor determines is right for you. If you are really active, you are under a lot of stress or it is extremely hot your treatment may not last as long. Absorption rate is based on cardiac output.

**Q. Is the therapy FDA approved?**
A. What the pellets are made of is FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and Respective State Pharmacy Boards. The PROCEDURE of placing pellets is NOT an FDA approved procedure. The pellets are derived from wild yams and soy, and are all natural and bio-identical. Meaning they are the exact replication of what the body makes.

**Q. How are they administered?**
A. Your practitioner will implant the pellets in the fat under the skin of the hip. A small incision is made in the hip. The pellets are inserted. No stitch is required.

**Q. Does it matter if I'm on birth control?**
A. No, the doctor can determine what your hormone needs are even if you are on birth control.

**Q. Are there any side effects?**
A. The majority of side effects is temporary and typically only happens on the first dose. All are very treatable. There are no serious side effects.

**Q. What if I'm already on HRT of some sort like creams, patches, pills?**
A. This is an easy transition. The doctor will be able to determine your needs even though you may be currently taking these other forms of HRT.

**Q. What if I've had breast cancer?**
A. Breast cancer survivors and/or those who have a history of breast cancer in their family may still be a candidate; however, this is to be determined by the physician. You should schedule a consultation with the Doctor.

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bioTE MEDICAL

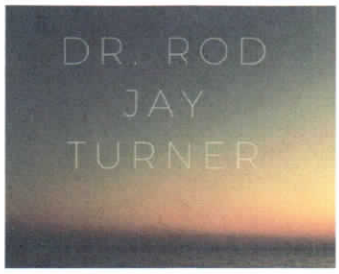
# Health Assessment for Women

Name: _____ Date: _____

Mail: _____

| SYMPTOMS (Please Check Box) | Never | Mild | Moderate | Severe |
|---|---|---|---|---|
| 1) Fatigue | ☐ | ☐ | ☐ | ☐ |
| 2) Mood Changes:<br>Irritability<br>Anxiety / Nervousness<br>Depression | ☐ | ☐ | ☐ | ☐ |
| 3) Decreased Mental Ability:<br>Memory Loss<br>Confusion<br>Loss of Focus | ☐ | ☐ | ☐ | ☐ |
| 4) Hot Flashes / Night Sweats | ☐ | ☐ | ☐ | ☐ |
| 5) Weight Gain:<br>Bloating<br>Excessive Belly Fat<br>Inability to Lose Weight | ☐ | ☐ | ☐ | ☐ |
| 6) Decreased Sex Drive:<br>Vaginal Dryness | ☐ | ☐ | ☐ | ☐ |
| 7) Sleep Problems:<br>Can't Stay Asleep<br>Can't Fall Asleep | ☐ | ☐ | ☐ | ☐ |
| 8) Cold Hands & Feet / Always Cold | ☐ | ☐ | ☐ | ☐ |
| 9) Hair loss / Breakage | ☐ | ☐ | ☐ | ☐ |
| 10) Dry Wrinkled Skin | ☐ | ☐ | ☐ | ☐ |

| FAMILY HISTORY (Please Check Box) | No | Yes |
|---|---|---|
| Heart Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Alzheimer's Disease | ☐ | ☐ |
| Breast Cancer | ☐ | ☐ |




# FEMALE NEW PATIENT PACKAGE

The contents of this package are your first step to restore your vitality.
Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

**2 weeks or more before your scheduled consultation:** Get your blood labs drawn at any CPL, Quest or LabCorp location. **IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY BLOOD DRAWS.** We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to two weeks for your lab results to be received by our office. Please faast for 12 hours prior to blood draw.**

## Your blood work panel MUST include the following tests:

____Estradiol
____FSH
____Testosterone Total
____TSH
____T4, Total
____T3, Free
____T.P.O. Thyroid Peroxidase
____CBC
____Complete Metabolic Panel
____Vitamin D, 25-Hydroxy (Optional)
____Vitamin B12 (Optional)
____Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

**Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:**

____FSH
____Testosterone Total
____CBC
____Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
____TSH, T4 Total, Free T3, TPO **(Needed only if you've been prescribed thyroid medication)**
____Estradiol

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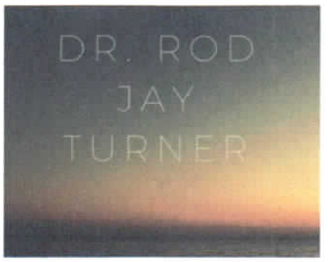


## LAB REQUEST (Female)

Dear Patient:

This is our generic lab form we have sent you to obtain your labs for your physician. Please take this form to your doctor so your insurance may cover it. It is important to have them include all the information on this lab request form and to include Our Physician's name as well. This way we will be sure to obtain a copy of the lab work which we will need for your office visit. Thank you!

Special note: If you are a Medicare/HMO patient, it is important that you ask your current Medicare/HMO provider to fill out their lab form with our necessary lab work. This way Medicare/ HMO may cover your lab work charges.

Patient Name:_____Date of Birth:_____

Please have these labs performed and faxed to:_____ FASTING ( ) YES ( ) NO

**( ) PRE-TREATMENT LEVELS**

- FSH, ESTRADIOL, TOTAL TESTOSTERONE
- TSH, TOTAL T4, FREE T3, T.P.O.
- CBC
- CMP
- VITAMIN B-12
- VITAMIN D, 25 HYDROXY
- LIPID PROFILE (optional)
  - ICD10: N95.1, E03.4, E34.9

**( ) POST-TREATMENT LEVELS**

- FSH
- TOTAL TESTOSTERONE
- ESTRADIOL
- LIPID PROFILE (optional)
  - ICD10: N95.1, E03.4, E34.9

_____

Signature

_____

Doctors Name