Bioidentical Hormone Replacement Therapy
Post Care

✔ No exercise for 3 days

✔ Shower is fine but do not submerge the area in a bath or a pool for 3 days

✔ Large bandage can be removed in 3 days

✔ Small bandage can be removed in 5 days

✔ Call immediately with any signs of infection, such as fever, increased pain, or discharge from incision site.

Family Practice @ Peachtree-Dunwoody
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Progesterone is a prescription hormone, given orally or by transdermal cream. Progestin are NOT the same as natural progesterone. Progestin may cause birth defects, damage to nerve cells, blood clots, and breast cancer. Progestin may cancel the protective effect of estradiol, and promote constriction of the coronary arteries to a significant degree. Natural progesterone, on the other hand, may protect the endometrium, preserve the beneficial effects of estrogen on the cardiovascular system and exert no negative effect on the blood vessels that supply your heart. Any time Estradiol is prescribed progesterone is also given to protect the uterus. Post-menopausal women will take this medication each day, whereas pre-menopausal women will it during the last half of their cycle.

Side effects of progesterone replacement may include, but not limited to: nipple or breast tenderness, drowsiness, fluid retention, slight dizziness, anxiety, difficulty sleeping, depression, acne, rashes, hot flashes, appetite increase and weight gain. Progesterone hormone therapy is prescribed to some women to regulate the menstrual cycle and increase fertility.

Thyroid Hormone is a prescription hormone take by mouth. Risk/adverse reactions include, but not limited to: palpitation and rapid heart rate, heart arrhythmias, excitability, and increased metabolism. Cardiac sensitivity is a contraindication to thyroid replacement therapy. Excess amounts may increase the risk for osteoporosis in some people and suppress the body's ability to manufacture its own thyroid hormone. Side effects may include, but not limited to: sleep disturbances, fine trembling of fingers, excessive hunger and thirst, sweating, anxiety, and headaches.

Dyhydroepiandrosterone - DHEA is a dietary supplement, given by mouth or by transdermal cream. Risks of DHEA replacement may include, but not limited to: acne or oily skin, hair growth on the face, arms or legs, acne in women, prostate enlargement in men, male pattern baldness, decreased HDL cholesterol, fatigue, mood changes, weight gain, and insomnia.

Melatonin is a non-prescription hormone given by mouth. Risks of Melatonin replacement include, but not limited to: nighttime exacerbation of asthma. It should be used cautiously when treating some autoimmune disease and leukemia, Hodgkin's disease or lymphoma. Side effects of Melatonin replacement may include, but not limited to: sleep disorders, bizarre dreams, headache, fatigue, stomach discomfort, and suppression of male sex drive.

Pregnenolone is a non-prescription hormone given by mouth. Risks with pregnenolone replacement include, but not limited to: exacerbation of various cancers and should be avoided by those with cancer in prostate, breast or uterus. Very high doses may cause cardiac arrhythmias. Side effects of Pregnenolone replacement may include, but not limited to: headaches, bloating, menstrual irregularities, heartburn, acne, agitation, sedation, rash and flushing.

Anastrozole is an oral medication prescribed to reduce excessive conversion of testosterone to estrogen. Side effects that you should report to your doctor or health care professional as soon as possible include, allergic reactions like skin rash, itching or hives, swelling of the face, lips, or tongue, and new unusual symptoms, breathing problems, chest pain, leg pain or swelling, or vomiting.

Alternatives to Hormone Replacement Therapy

I understand the reasonable alternatives to hormone replacement therapy, which include:

- Leaving the hormone levels as they are doing nothing. Risks may include, but are not limited to: experiencing symptoms of hormone deficiency, and increased risk for aging related diseases or dysfunction resulting from declining hormone levels as they appear clinically.
- Treating the symptoms of declining hormone levels as they develop with non-hormonal therapies. Risks may include, but are not limited to: increased risk for aging-related diseases resulting from declining hormone levels.

My Compliance Obligation While Receiving Hormone Replacement Therapy

I agree to comply with the proposed treatment and therapy as prescribed, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, administrating the hormone(s) that may be prescribed to me, and consent to periodic monitoring, when requested, which may include laboratory monitoring of blood or urine chemistries and hormone levels, physical examination, regular screening evaluations.

I agree to notify you regarding all signs or symptoms of possible reactions to my therapy.
Consent for Hormone Replacement Therapy

1. the undersigned, authorize and give my informed concern to FP@PD Medical Professionals for the administration of hormone replacement therapy.

Expected Benefits of Hormone Replacement Therapy

Expected benefits include control of symptoms associated with declining hormone levels. Possible benefits of this therapy may help prevent, reduce or control physical diseases and dysfunctions associated with declining hormone levels, through hormonal replacement.

Risk in Pregnancy:

Testosterone is teratogenic and may cause abnormal fetal development. Exposure of a female fetus to testosterone should NOT use this therapy. Testosterone is teratogenic and may cause abnormal fetal development. Exposure of a female fetus to testosterone carries a warning of Pregnancy Category X, which means women who are pregnant, may become pregnant or who are nursing female testosterone is not yet approved by the FDA and therefore is used “off-label.” Testosterone products may also cause hair loss. Injected testosterone can induce hoarseness, menstrual irregularities, and clitoral enlargement. Male pattern baldness, breast enlargement, diminished sperm production, and a reduction in the size of testicles may develop in men. Testosterone replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone. The concurrent use of testosterone corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease.

Immediate side effects (occurring approximately no more than 6% of users) include, but not limited to: application site reaction, headache, hypertension (high blood pressure), abnormal liver function tests, and non-cancerous prostate disorder. Other side effects may include greasy hair and skin, a strong body odor, hyper libido, hirsutism, and aggressiveness. In women, testosterone may also cause hair loss. Injected testosterone can induce hoarseness, menstrual irregularities, and clitoral enlargement.

Immediate side effects: stimulation of benign and malignant prostate tumor. Testosterone replacement is contraindicated in men with known prostate cancer. Inconclusive studies show that testosterone replacement therapy can increase risk for heart attack, stroke or effects of obstructive sleep apnea.

Side Effects of testosterone replacement may include, but not limited to: an increase in the red blood cells, determined by periodic measuring of your red blood. It is not a common occurrence and generally poses no risk: it can be corrected by donating blood or with a therapeutic phlebotomy. Male pattern baldness, breast enlargement, diminished sperm production, and a reduction in the size of testicles may develop in men. Testosterone replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone. The concurrent use of testosterone corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease.

Expected Benefits of Hormone Replacement Therapy

Some of the following risks adverse reactions are derived from the official Food and Drug Administration “FDA” labeling requirements for these drugs, for therapeutic drug levels in the blood stream. My healthcare provider may prescribe these medications at dosages designed to achieve physiological levels of hormones in my blood stream or urine generally associated with those of a 20-35 year old person and would be within the “normal” or “average” blood concentration of that age group.

General

I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by medical community as new, controversial, and unnecessary by the Food and Drug Administration.

I understand that there are risks (both known and unknown) to any medical procedure, treatment and therapy, and that it is not possible to guarantee or give assurance of successful results. I acknowledge and accept these known and unknown general risks.

Testosterone A prescription hormone, given by injection, sublingual or subdermal pellet.

Risk of testosterone replacement include, but not limited to: stimulation of benign and malignant prostate tumor. Testosterone replacement is contraindicated in men with known prostate cancer. Inconclusive studies show that testosterone replacement therapy can increase risk for heart attack, stroke or effects of obstructive sleep apnea.

Side Effects of testosterone replacement may include, but not limited to: increased body fat, fluid retention, uterine bleeding, depression, headaches, impaired glucose tolerance, and aggravation of migraines.

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I agree to comply with all other healthy lifestyle activities that have been individually recommended for me. I have completely disclosed my medical history, including any chronic or autoimmune conditions. I included prescription and non-prescription medications that I am currently taking or plan on taking during my treatment, as well as any other over the counter medications, recreational drugs, or social substances, herbs, extracts, and other dietary supplements. I agree to comply with the recommendations regarding the continuation or discontinuation of these preparations.

In the future I will receive recommendation in advance from you before stopping any prescribed therapeutic regimens or taking additional preparations that are not recommended by you.

I clarify that I am under the care of a physician(s) for any and all other medical conditions.

Consent for Bio-Identical Hormone Therapy Pellet Insertion Procedure

I allow the FP@PD medical professional and any assistant(s) to perform the following procedure and tests as deemed necessary.

I have discussed other Bio-Identical Hormone delivery systems such as injection, transdermal creams and patches, and oral hormones. I have chosen pellet insertion as my best option for hormone replacement therapy.

I am responsible for any charges associated with such procedures, labs or tests whether or not I have insurance.

I understand that results are not guaranteed and there will be no refunds given.

The procedure has been fully explained to me. Benefits and risks have been discussed such as possible slight bruising, minor bleeding at the insertion sight, possible infection and/or extrusion of the pellets.

Post Care instructions have been discussed and a copy of instructions have been given to me.

I have not provided a mammogram report (women only).

Research and Economic Interests

I understand that the prescribing practitioner is not engaged in any personal research and has no economic interests unrelated to my immediate care or treatment that may affect the physician’s choice of treatment or medical judgement. I certify that I have been given opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base an informed consent.

I do now attest to reading and fully understanding this form and the contents and clinical meanings of such, and discussing these procedures with my healthcare provider and consent to this treatment, hereby affix my signature to this authorization for this proposed long term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meaning of its writing and expressions.

Patient (Print Name): ____________________________________________

Patient Signature: ____________________________________________

Date: __________________

Medical Professional (Print Name): ______________________________

Medical Professional Signature: _________________________________

Date: __________________
Have you ever had or are you currently experiencing any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
<td>Acne</td>
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<tr>
<td>Anorexia</td>
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<td>Anemia</td>
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<tr>
<td>Asthma</td>
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<td>Bleeding Tendency</td>
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<tr>
<td>Blood Disorder</td>
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<tr>
<td>Bruising Tendency</td>
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<tr>
<td>Cancer-Active</td>
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<tr>
<td>Cancer- Remission</td>
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<tr>
<td>Cardiac Disorder</td>
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<tr>
<td>Cold Sores</td>
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<tr>
<td>Current Cold/Flu</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy/ Seizures</td>
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<td>Hepatitis Type</td>
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<tr>
<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>HIV</td>
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<tr>
<td>Infection Currently</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Leukopenia</td>
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<tr>
<td>Liver Disease</td>
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<tr>
<td>Low Blood Pressure</td>
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</tbody>
</table>

Please list any other conditions:

If you answered yes to any of the above questions, please state how this medical condition is being managed. Name of Physician, Name of Medications, other Treatments, etc.

I attest that the above information is accurate to my knowledge and will alert FP@PD if any information about my health changes.

Client Signature: ____________________________ Date: ________________

Witness Signature: __________________________ Date: ________________

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# Hormone Questionnaire

**HORMONE QUESTIONNAIRE**

Name: ____________________________ DOB: __________ Date: ________________

<table>
<thead>
<tr>
<th></th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progesterone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty Concentrating</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Can’t Sleep (Insomnia)</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Depressed or Unhappy</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Anxious</td>
<td>10</td>
<td></td>
<td></td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Moodiness/Emotional Swings</td>
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<tr>
<td>Painful and Swollen Breasts</td>
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<tr>
<td>Weight Gain/Bloating</td>
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<tr>
<td>PMS</td>
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<tr>
<td><strong>Estrogen</strong></td>
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<tr>
<td>Night Sweats</td>
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<tr>
<td>Memory Loss</td>
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<td>Hot Flashes</td>
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<tr>
<td>Vaginal Dryness</td>
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<tr>
<td>Dry Hair/Skin</td>
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<tr>
<td>Incontinence</td>
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<tr>
<td>Frequent Urinary Infection</td>
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<td>Inability to Reach Orgasm</td>
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<td>Painful Intercourse</td>
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<tr>
<td><strong>Testosterone</strong></td>
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<tr>
<td>Loss of Libido</td>
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<td>Lack of Desire to be Intimate</td>
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<td>Loss of Motivation</td>
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<tr>
<td>Flat Mood</td>
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<tr>
<td>Diminished Well Being</td>
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<tr>
<td><strong>General Well Being</strong></td>
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<tr>
<td>Change of Bowel Movement</td>
<td></td>
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<tr>
<td>Change of Weight</td>
<td>Increase:</td>
<td>Decrease:</td>
<td></td>
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<tr>
<td>Change of Stress LEVEL</td>
<td>Yes/No</td>
<td>Current stress level:</td>
<td></td>
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## Medications/Supplements

<table>
<thead>
<tr>
<th>Medications/Supplements</th>
<th>Reason for taking</th>
<th>Date Began</th>
<th>Dose</th>
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### Have you had any allergic reaction to the following?

- **Local anesthetics (ex: Lidocaine)**
  - Y
  - N

- **Penicillin or other antibiotics**
  - Y
  - N
  - **If yes, please explain** _________________

- **Sulfa drugs**
  - Y
  - N

- **Latex**
  - Y
  - N

- **Sedatives**
  - Y
  - N

- **Blood Iodine**
  - Y
  - N

- **Aspirin**
  - Y
  - N

- **Drugs**
  - Y
  - N
  - **If yes, please explain** _________________

- **Food**
  - Y
  - N
  - **If yes, please explain** _________________

- **Other**
  - Y
  - N
  - **If yes, please explain** _________________

**If yes, what happens?**

### Please list any relevant family history:

________________________________________________________________________________________

________________________________________________________________________________________

### List Yes(Y) No (N) Past (P) regarding use of the following:

- **Steroids:**
  - Y
  - N
  - P

  **If yes, for what condition and what dosage?** _________________

- **Smoking:**
  - Y
  - N
  - P

  **If yes, how much per day?** _________________

**Smoking in any amount compromises the healing process and may negatively affect the outcome of your treatment.**

- **Analgesics:**
  - Y
  - N
  - P

- **Caffeine:**
  - Y
  - N
  - P

  **Ounces per day if Yes:** _________________

- **Alcohol:**
  - Y
  - N
  - P

  **If yes, How much per week?** _________________

- **Recreational Drugs:**
  - Y
  - N
  - P
PATIENT INFORMATION AND INTAKE FORM

Date: ______________

First  Middle  Last

DOB: ______________  Age: ______________

Address: ____________________________________________________________

City: ______________  State: ______________  Zip: ______________

Telephone: ______________  Work Number: ______________  OK to Email or Leave Message? Y / N

Email: __________________________________________  Location: _____________________________

How did you hear about us? ____________________________________________

Ethnic Background: _____________________________________________________

Marital Status (please circle)  Married  Single/Divorce  Widow  Living with Significant other

If emergency please contact: ____________________________________________  Contact number: ______________

Relationship to you: _________________________________________________

PATIENT MEDICAL HISTORY

State the reason(s) for your visit and describe any symptoms you are experiencing:

_____________________________________________________________________

_____________________________________________________________________

Immunizations/Surgeries (including tonsils, gallbladder, appendix, cosmetic):

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year</th>
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<table>
<thead>
<tr>
<th></th>
<th>Do you take any prescription or over the counter medications? (Include herbal supplements) Please list:</th>
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<tbody>
<tr>
<td>No</td>
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<td>No</td>
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**The above health questionnaire is accurate. I agree to disclose all changes to my health at future visits.**

Print Name: ____________________________ Signature: ____________________________ Date: ________________

Date of Birth: ____________________________ PA/NP/MD Signature: ____________________________ Date: ________________
Patient Name: ___________________________ Date: ______________

Chief Complaint: Anxiety, concentration, Decreased Energy, Decreased Libido, Depression, Dry Skin, Fatigue
Hot Flashes, Hair Loss, Insomnia, Irritability, Joint Pain, Memory, Muscle Loss, Palpitations, Rash/Acne
Sensation, Sweating, Swelling/Edema, Weight Gain

I-S-W Sleep, I-S-W Concentration, I-S-W Memory

Allergies: ___________________________ Medication list updated:__________________________

PMH: Post/Peri Menopausal, HTN, DM, DJD, TIA, CVA

PSH: Hysterectomy Total/Partial, Appy, GB, Hernia

FH: CVA, HTN, DM, DJD

SH: Tobacco, Etoh, Narcotics Stress

ROS: Skin _______ EENT _______ CV _______ RESP _______ GI _______ GU _______ ENDO _______ M/S ______

HEM _______ Neuro _______ Psych _______ Positives: ___________________________

Physical Exam: Temp _______ Pulse _______ Resp _______ BP _______ \\

<table>
<thead>
<tr>
<th>Positives</th>
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<td>___________</td>
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Lab Rev: Testosterone _______ Free Testosterone _______ Estradiol _______ Progesterone _______ TSH ______

ft3 ______ ft4 ______ DHEAs _______ IGF-1 _______ Vit D _______ MCV ______ Additional Labs: ___________

Assessment

Plan: Pellet therapy: Testosterone: _______ Estradiol: _______ RT LT Hip

IM hrt: Testosterone: _______ ml 200mg/ml 100mg/ml Estratest: _______ ml 4/90 sig:q ______ d# ______ 4d post # ______ labs

Oral: ______ mg OMP/OMP+ P t_______ po qhs d_______ |_______ #x = ______

Neutraceutical: DMI t_______po qd | DHEA ______ mg t_______po qam | P5P ______ mg t_______po qam | mvm t_______po qam

Other instructions: ___________________________

ETC Labs- E P T DHEA-s TSH ft3 ft4 TPO TGA CBC CMP Vit D IGF-1 GSH Food Panel HLA DQ _______ D W M

F/U Dr. _______ D W M F/U Nutrition _______ D W M F/U MA _______ D W M Signature: __________________