SottoPelle®
Hormonal Balance.Well-Being.

Dear Patient:

You've made the right choice towards getting your life back on track. SottoPelle® is a superior and remarkable method of Bio-Identical Hormone Replacement Therapy (BHRT). This type of therapy has been documented and researched in medical journals since 1939. Not only will you regain the energy, libido and vitality of your youth; SottoPelle® is here to help you get back to your normal physiological state of well-being. *Won't that be a welcome relief?*

Your appointment is scheduled on:

Day & Date: _____ Arrival Time: _____ Time: _____

SottoPelle Provider: _____ Location: _____

Please notify us 48 hours in advance of a cancellation

Inside your packet, we've enclosed many pages for you to fill out and ones filled with information.

Lab work: Please go to the lab location we have provided for you *within the next few days* to ensure that your lab results are available by your scheduled appointment date. Please check with your insurance carrier prior to receiving your lab work to find out if your insurance covers the lab work. If you have a high deductible or your insurance does not cover your lab work, please call your SottoPelle® office price ranges. This is a fasting test; please fast for 8-10 hours before your lab work.

Special Note: If you are a Medicare/HMO patient, it is important that you ask your current Medicare/HMO provider to complete their lab form with our necessary lab work. Medicare/HMO may cover your lab work charges. In addition, **please complete all the enclosed new patient forms and bring them with you to your appointment.**

Pages to fill out and bring with you to your appointment. Please do not put them in the mail or fax.

- ☐ **Female Patient Questionnaire**
- ☐ **Medicare Non-Assigned Form** (if applicable)
- ☐ **SottoPelle® Acknowledgement Form**
- ☐ **Patient Consent to Leave Detailed Message**
- ☐ **Authorization for Release of Information**

Along with a copy of your most recent: ☐ **Mammogram** ☐ **Pap** ☐ **Bone Density** (if possible)

We are committed to making sure your treatment and visits with us are as positive as they can be. We understand you are a unique individual and we strive to provide you with the highest quality medical care. Our primary concern is to restore you to a state of "well-being" and optimum health! Our patients are treated with compassion and respect. We encourage you to openly express your needs and concerns to our staff.

We look forward to seeing you soon.

Here's to your well-being!

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Female New Patient Generic Lab Request

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 provider'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 completed and faxed to: _____

FASTING: YES NO

□ **PRE-TREATMENT LEVELS**

FSH TSH ESTRADIOL TESTOSTERONE - TOTAL LIPID PANEL

- DX: N95.1, E34.9, E75.5, E07.89

□ **POST-TREATMENT LEVELS**

FSH ESTRADIOL TESTOSTERONE - TOTAL

- DX: N95.1, E34.9

□**BASIC THYROID PANEL**

TSH TOTAL T/3 AND T/4 FREE T/3 AND T/4

- DX: E07.89

□ **COMPLETE THYROID PANEL**

TSH TOTAL T/3 AND T/4 FREE T/3 AND T/4 ANTI-TPO ANTI-TG

- DX: E07.89

□ **EBV PANEL**

- **EBV IgG ANTIBODIES**
- **EBV IgM ANTIBODIES**
- **EBV ANTINUCLEAR ANTIBODIES**
  - DX: R53.83

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FEMALE PATIENT INFORMATION

Name: _____ Today's Date: _____
LAST FIRST MIDDLE

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone:

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _____
LAST FIRST MIDDLE

Spouse's Date of Birth _____

Spouse's Employer: _____

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____

Contact Information: _____
HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: _____

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What is the reason for your visit today? Please describe the symptoms & be specific:

How did you hear about us:

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SYMPTOM CHECKLIST

Please indicate how often you have the following

Night sweats:	☐ Frequently	☐ Rarely	☐ Never
Hot flashes/hot flushes:	☐ Frequently	☐ Rarely	☐ Never
Pain with intercourse:	☐ Frequently	☐ Rarely	☐ Never
Vaginal dryness:	☐ Frequently	☐ Rarely	☐ Never
Sleeping problems:	☐ Frequently	☐ Rarely	☐ Never
Urine leaks when you cough or sneeze:	☐ Frequently	☐ Rarely	☐ Never
Difficulty concentrating/memory loss:	☐ Frequently	☐ Rarely	☐ Never
Mood swings:	☐ Frequently	☐ Rarely	☐ Never
Migraines:	☐ Frequently	☐ Rarely	☐ Never
Depression:	☐ Frequently	☐ Rarely	☐ Never
Anxiety:	☐ Frequently	☐ Rarely	☐ Never
Decrease in sexual desire:	☐ Frequently	☐ Rarely	☐ Never
Decrease in energy level:	☐ Frequently	☐ Rarely	☐ Never
Loss of memory:	☐ Frequently	☐ Rarely	☐ Never
Foggy thinking:	☐ Frequently	☐ Rarely	☐ Never
Muscle and/or joint pain:	☐ Frequently	☐ Rarely	☐ Never

Please check the boxes below if they apply to how you have dealt with the above symptoms

Herbal medications/supplements ☐ YES ☐ NO

Please specify how: _____

Change of diet: ☐ YES ☐ NO

Please specify how: _____

Layered clothing: ☐ YES ☐ NO

Please specify how: _____

Increase exercise: ☐ YES ☐ NO

Please specify how: _____

Other: _____

_____

_____

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GYN HISTORY

Are you sexually active: ☐ YES ☐ NO

Have you been sexually active: ☐ YES ☐ NO

Do you have pain with intercourse: ☐ YES ☐ NO

What type of contraception are you currently using (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

What type of contraception have you used in the past (Please check below all that apply):

☐ Pills ☐ IUD ☐ Foam ☐ Condoms

☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal

☐ Implants ☐ Depo ☐ Provera

☐ Other: _____

Are you having any problems with your method of birth control: ☐ YES ☐ NO

Have you ever had any vaginal, cervical and/or tubal infection: ☐ YES ☐ NO

If yes, please check below call that apply:

☐ Gardnerella ☐ Syphilis ☐ Condyloma ☐ Bacterial Vaginitis

☐ Yeast ☐ PID ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Warts

☐ Other: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear ☐ YES ☐ NO

If yes, how was it treated (please check below all that apply):

☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy

☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Excition

Have you ever had cervical cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had uterine cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Have you ever had ovarian cancer: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have trouble leaking urine: ☐ YES ☐ NO

Do you have any breast lumps, tenderness or discharge: ☐ YES ☐ NO

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Have you ever had a mammogram: ☐ YES ☐ NO

If yes, was it normal: ☐ YES ☐ NO

Date of last mammogram: _____

Do you do self breast exams: ☐ YES ☐ NO

Do you have PMS symptoms: ☐ YES ☐ NO

If yes, are you currently undergoing treatment: ☐ YES ☐ NO

If yes, what type of treatment: _____

Do you have any uterine abnormality: ☐ YES ☐ NO

Do you have a history of infertility: ☐ YES ☐ NO

Do you have a history of DES exposure ☐ YES ☐ NO

Do you have fibroids of the uterus: ☐ YES ☐ NO

Have you had abnormal bleeding in the past year: ☐ YES ☐ NO

If yes, please describe: _____

At what age did you start menopause: _____

MENSTRUAL HISTORY

If you no longer have periods, please check reason

☐ Natural ☐ Hysterectomy ☐ Ablation ☐ Menopause

Do you have a uterus: ☐ YES ☐ NO

First day of last period: _____

Typically, how many days do your periods last: _____

Are your periods regular: ☐ YES ☐ NO

How many days are between the start of your periods: _____

Has the flow of your period changed in any way: ☐ YES ☐ NO

If yes, please explain the change: _____

Does bleeding occur between your normal period cycle: ☐ YES ☐ NO

Do you suffer from cramps during your periods: ☐ YES ☐ NO

If yes, please check the pain associated with the cramps:

☐ MILD ☐ MODERATE ☐ SEVERE

What medicine, if any, are you currently taking for your cramps: _____

SOCIAL HISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please try list the number you smoke per day on average: _____

Please list the number of years you have been smoking: _____

Do you use recreational drugs: ☐ YES ☐ NO

Do you drink alcohol: ☐ YES ☐ NO

If yes, what type of alcohol do you drink: _____

How many drinks **per week**, on average, do you drink: _____

Are you using any form of Testosterone or Hormone Therapy: ☐ YES ☐ NO

If yes, please check which type:

☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

MEDICAL HISTORY

Do you have **diabetes**: ☐ YES ☐ NO

Do you have or have you ever had **hypertension**: ☐ YES ☐ NO

Do you have **heart disease**: ☐ YES ☐ NO

Have you ever had a **heart attack**: ☐ YES ☐ NO

Have you ever had a **stroke**: ☐ YES ☐ NO

Do you have a **heart murmur**: ☐ YES ☐ NO

Do you have or have you ever had **kidney disease**: ☐ YES ☐ NO

Have you ever been treated for a **psychiatric disorder**: ☐ YES ☐ NO

If yes, please name the disorder: _____

Have you ever had **rheumatic fever**: ☐ YES ☐ NO

Do you have **mitral valve prolapse**: ☐ YES ☐ NO

Have you ever had a **urinary tract infection**: ☐ YES ☐ NO

Have you ever had **hepatitis**: ☐ YES ☐ NO

If yes, please check which type:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had **liver disease**: ☐ YES ☐ NO

Have you ever had **varicose veins**: ☐ YES ☐ NO

Have you ever had **phlebitis**: ☐ YES ☐ NO

Do you have any **thyroid problems**: ☐ YES ☐ NO

If **yes**, please check the problem

☐ Low Function ☐ Overactive ☐ Goiter ☐ Hashimoto's

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Have you ever had a **blood transfusion**:	☐ YES	☐ NO
Do you have **asthma, emphysema** or **chronic bronchitis**:	☐ YES	☐ NO
Do you have or have you ever had **leukemia**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Please check the type of treatment:	☐ Surgery	☐ Radiation
Do you have or have you ever had **lymphoma**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Please check the type of treatment:	☐ Surgery	☐ Radiation
Do you have or have you ever had **colon cancer**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Please check the type of treatment:	☐ Surgery	☐ Radiation
Do you have or have you ever had **colon polyps**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Do you have or have you ever had **multiple myeloma**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Do you have or have you ever had **lung cancer**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Do you have or have you ever had **rectal cancer**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO
Please check the type of treatment:	☐ Surgery	☐ Radiation
Do you have or have you ever had **breast cancer**:	☐ YES	☐ NO
If yes, are you currently undergoing any treatment:	☐ YES	☐ NO

Please check the type of treatment

☐ Lumpectomy ☐ Mastectomy ☐ Radiation Therapy ☐ Chemotherapy

Do you have any **drug allergies**:	☐ YES	☐ NO

If yes, please list the drugs you are allergic to:

_____

Please list **all** major surgeries (including year and reason):

_____

_____

_____

_____

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Please list any other operations/hospitalizations (including year and reason):

Have you ever had any anesthesia complications: ☐ YES ☐ NO

If yes, please explain:

Are you currently or have you ever been **anemic**: ☐ YES ☐ NO

Do you have an Internist or Family Physician: ☐ YES ☐ NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____

Are you currently taking any medications: ☐ YES ☐ NO

Please list the medications you are currently taking and the dosage amount:

Have you ever had your cholesterol checked: ☐ YES ☐ NO

If yes, what was the date it was last checked: _____

How was your cholesterol: ☐ Low ☐ Normal ☐ High

Do you have **arthritis**: ☐ YES ☐ NO

If yes, what type: _____

Do you have **lupus**: ☐ YES ☐ NO

Do you have **scleroderma**: ☐ YES ☐ NO

Do you have **rheumatoid arthritis**: ☐ YES ☐ NO

Have you had **blood clots in your legs or lungs**: ☐ YES ☐ NO

Do you have problems with **water retention**: ☐ YES ☐ NO

Do you have problems with **swelling**: ☐ YES ☐ NO

Do you have problems with **bloating**: ☐ YES ☐ NO

Do you have **osteopenia**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you have **osteoporosis**: ☐ YES ☐ NO

If yes, how was it treated: _____

Do you suffer from **hair loss**: ☐ YES ☐ NO

Do you suffer from or have you had **acne**: ☐ YES ☐ NO

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FAMILY HISTORY

Do you have a family history of **breast cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **colon cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **ovarian cancer**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **osteoporosis**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **diabetes**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **hypertension**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **heart disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

Do you have a family history of **kidney disease**: ☐ YES ☐ NO

If yes, with who in your family history: _____

At what age did your mother go through menopause: _____

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Authorization for Release of Medical Information

According to HIPAA and Governmental rules all patients are asked to sign this release form indicating that you understand that our office follows all HIPAA rules with respect to protected health information.

I hereby authorize the use/disclosure of my health information as described below, including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

Records which may be released include: all medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports.

I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy delivered in person, by mail, email or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to receive and use this information:

☐ Insurance Company (If checked, please complete "Insurance Information" on back side)

☐ Pharmacy (release of name, date of birth, allergies only)

☐ Significant Other or Family Member: _____

I further authorize you to provide to and discuss with your Provider and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

1. I understand that my health care will not be affected if I do not sign this form.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not revoke this authorization, it will automatically expire six months from its date.
3. I understand this is not in relation to requesting medical records for me for another physician. There is a separate form that is filled out for that request which I can obtain by contacting the medical records department.
4. I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

_____ _____

Signature of Patient or Representative Date

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Female Release of Medical Records Consent Form

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for your Provider to have your current pap and mammogram report prior to your next HRT appointment.

Date: _____

To: _____
Your Doctor's Name

_____
Address

_____
City State Zip

Phone: (___)___-____

Fax: (___)___-____

I, _____, authorize _____
(Your Name) (Your Doctor's Name)

to disclose and release any individually identifiable health information related to me **from the last 2 years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ Mammogram Report Only
- ☐ Pap Report
- ☐ Bone Density
- ☐ Ultrasounds
- ☐ Endometrial Biopsy
- ☐ Any current hormone labs

Are there any restrictions on PHI to be disclosed? Yes No

If yes, please explain: _____

_____

WE DO NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!

Send To: _____
_____
_____
_____
_____
Phone: _____
Fax: _____

_____
Print Name

_____
Date of Birth

_____
Patient Signature

_____
Date

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HIPAA-Health Insurance Portability and Accountability Act

YOUR RIGHTS- Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION - You have the right to inspect and or/obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES - With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence)
- To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)
- For judicial or administrative proceedings (for example pursuant to a court order, subpoena or discovery request)
- For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)
- To avert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
- For compliance with worker's compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient:

_____ _____

Signature Date

Witness:

_____ _____

Signature Date

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Patient Consent To Leave Detailed Message/Information

Dear Patient:

Your Provider has adopted a policy that requires their staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect the Provider's staff from violating the patient's confidentiality. If the Provider's staff does not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, the Provider's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give consent to my Provider and/or staff of the Provider to leave a message regarding treatment, test results or other necessary information.

Please print phone numbers on line(s):

1._____ On answering machine at home
(Home Phone Number)

2._____ On cell phone voice mail
(Cell Phone Number)

3._____ On voice mail at work
(Work Number)

_____ _____
Patient Signature Date

.....

I do **NOT** consent to any messages being left on my message machine other than office name and phone number.

_____ _____
Patient Signature Date

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Female Hormone Symptom Diary

Name: _____

SYMPTOMS: Rate 1-10 (10 is the worst)	Before Treatment Date:	Month #1 Date:	Month #2 Date:	Month #3 Date:	Month #4 Date:	Month #5 Date:	Month #6 Date:
Fatigue							
Insomnia							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Depression							
Anxiety							
Muscle Weakness							
Migraine Headaches							
Hair Loss							
Dry Skin							
Facial Hair							
Nausea							
Muscle Pain							
Joint Pain							
Foggy Mind							
Loss of Well Being							
Poor Results from Exercise							
Painful Intercourse							
Vaginal Dryness							
Night Sweats							
Hot Flashes							

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Symptom Questionnaire

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0= you never experience the symptom
5= you experience the symptom severely and all the time

Dermatological

Dry Skin	__/5
Course Skin	__/5
Itchy Skin	__/5
Dry, course hair	__/5
Thinning/loss of hair	__/5
Thinning eyebrows	__/5
Brittle or ridges on nails	__/5
Excess wax in ears	__/5
Decreased sweat	__/5
Paleness of skin or lips	__/5
TOTAL	**__/50**

Metabolism

Lethargy (low energy)	__/5
Sensation of cold	__/5
Heat intolerance (not hot flashes)	__/5
Slow speech (non memory)	__/5
Weight gain with little food intake	__/5
Lack of appetite	__/5
Lack of libido	__/5
TOTAL	**__/30**

Dryness (sicca)

Dry eyes	__/5
Dry skin	__/5
Dry mouth	__/5
Dry nose	__/5
Dry sinuses	__/5
Dry vagina	__/5
TOTAL	**__/30**

Gastrointestinal

Constipation	__/5
Diarrhea	__/5
Irritable bowel syndrome	__/5
GERD (reflux disease)	__/5
TOTAL	**__/20**

Reproductive

Delayed menstrual flow	__/5
Excessive menstrual flow	__/5
Painful menses	__/5
Impotence (men only)	__/5
TOTAL	**__/20**

Mental/Emotional Well-being

Depression	__/5
Irritability/mood swings	__/5
Nervousness	__/5
Anxiety	__/5
Impaired memory	__/5
Impaired focus	__/5
TOTAL	**__/30**

Cardiovascular/Respiratory

Chest pain	__/5
Palpitations	__/5
Atrial fibrillation	__/5
Chronic cough of *unknown reason*	__/5
Airflow obstruction (non smokers)	__/5
Shortness of breath on physical exertion	__/5
Shortness of breath in general	__/5
TOTAL	**__/30**

Swelling

Swollen ankles	__/5
Swollen wrists	__/5
Swollen eyelids	__/5
Swollen, thick tongue	__/5
Swollen face	__/5
TOTAL	**__/25**

Musculoskeletal

Muscle weakness	__/5
Unexplained tingling or Numbness	__/5
Body aches	__/5
Muscle pain	__/5
Joint pain	__/5
Carpal tunnel syndrome	__/5
Plantar fasciitis	__/5
TOTAL	**__/35**

Sleep

Difficulty getting to sleep	__/5
Difficulty staying asleep	__/5
Wake unrefreshed	__/5
Sleep apnea	__/5
Snoring	__/5
TOTAL	**__/25**

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
__Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
__Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
__Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)

SottoPelle

Consent for Hormone Implantation

1. I, _____, authorize _____
(Patient Name) (Treating Provider)

or a designated medical professional, Physician or Practitioner to perform the following operation or procedure: STERILE SURGICAL PLACEMENT OF HORMONE PELLETS UNDER THE SKIN.

2. I understand the reason for the procedure is: hormone replacement therapy using Estradiol and/or Testosterone.

3. RISKS: Risks that may be associated with this particular operation or procedure include: bleeding and/or infection

4. LOCAL ANESTHESIA: The administration of anesthesia also involves risks; most importantly, a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the medical professional, physician or practitioner responsible for these services.

5. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure any condition I may have.

6. PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

7. PROVIDER'S DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____ _____
Treating Provider Signature Date

SottoPelle®
Hormonal Balance/Well Being

Female Estradiol & Testosterone Hormone Acknowledgement Insertion Form

General Bio-identical hormone pellets are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone which are made in the ovaries and adrenal gland. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Birth Control Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is listed as category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is:

☐ Abstinence	☐ Hysterectomy	☐ Menopause	☐ Other:
☐ Birth control pill	☐ IUD	☐ Tubal Ligation	_____

Benefits and Risks I have been told I may have testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. The potential benefits of testosterone include a possible increase in my bone density, short term memory, protect against Alzheimer's, increase in my energy, my libido, and my sense of well-being. I may also see testosterone decreasing the frequency and severity of my headaches. I have also been told that I may have estradiol pellet(s) inserted under my skin to also achieve a steady state of estradiol in my body. The potential benefits of estradiol include possible elimination of my mood swings, anxiety and irritability, cardiovascular protection and protect from developing colon cancer and brain dysfunction.

The above potential benefits come with some risks. Pellet insertion is not the usual and customary means of hormone replacement. In cases of excessive consumption of synthetic testosterone by males, adverse conditions included heart problems and elevated cholesterol. Pellet therapy is low-dose, non-oral and uses natural testosterone, and is not associated with such problems.

In a rare number of patients, the body will convert testosterone to DHT which can cause acne or hair loss. The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and cause bleeding.

Side effects or complications are substantially more rare than in the case of non-bioidentical hormones, but may include: bleeding, infection and pain at the insertion site; lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice –which is reversible; clitoral enlargement—which is reversible.

Charges I understand there is a charge which varies depending on the number of pellets I may receive. The precise amount is to be determined by your medical provider. I understand payment is due in full at the time of service.

My signature below certifies that I have read and understood the above and my acknowledgement that I have been encouraged to ask any questions regarding pellet therapy and all of my questions have been answered to my satisfaction. I also acknowledge that the risks and benefits of this treatment have been explained to me and that I may experience one or more of the complications listed above. I accept these risks and benefits and consent to the insertion of hormone pellets under my skin.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

SottoPelle
Hormonal Balance, Well-Being.

PAP and Transvaginal Ultrasound Waiver for Estradiol and Testosterone Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous
(Patient Name)
bio-identical Estradiol & Testosterone pellet therapy with _____.
(Treating Provider)

For today's appointment, I **do not** have a

☐ PAP Smear report for this reason:

- ☐ My decision not to have one.
- ☐ My doctors decision to not have one, Dr. _____ Please provide a note from the aforementioned physician outlining the rationale.

☐ Transvaginal Ultrasound for this reason:

- ☐ My decision not to have one.
- ☐ My doctors decision to not have one, Dr. _____ Please provide a note from the aforementioned physician outlining the rationale.

☐ Unable to provide report at this time.

Pap report information:	Transvaginal Ultrasound Information:
Date of Pap Smear report: _____	Date of Transvaginal Ultrasound: _____
My results were: ☐ Normal ☐ Abnormal	My results were: ☐ Normal ☐ Abnormal

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a pap and/or Transvaginal Ultrasound since I receive estrogen. _____ (initials of patient)

PAP and/ or Transvaginal Ultrasound are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a PAP and/ or Transvaginal Ultrasound may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of increase of such undetected cancer. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or ovarian, endometrial and/or cervical issues) that may be sustained by me in connection with my decision to refrain from obtaining a PAP and/ or Transvaginal Ultrasound. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo a PAP and/ or Transvaginal Ultrasound. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date

SottoPelle®
Hormonal Balance & Well-being

Mammogram Waiver
for Estradiol and Testosterone Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous
(Patient Name)

bio-identical Estradiol & Testosterone pellet therapy with
_____.
(Treating Provider)

For today's appointment, I **do not** have a Mammogram Report for this reason:

☐ My decision not to have one.

☐ My doctors decision to not have one, Dr. _____. Please provide a note from the aforementioned physician outlining the rationale.

☐ Unable to provide report at this time.

Mammogram report information:		
Date of Mammogram report:	_____	
My results were:	☐ Normal	☐ Abnormal

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive estrogen. _____ (initials of patient)

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast or uterine issues) that may be sustained by me in connection with my decision to refrain from obtaining a mammogram exam. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless my Treating Physician, SottoPelle®, Inc., and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo a mammogram exam. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date

SottoPelle®
Hormonal Balance. Well-being.

Female Release of Medical Records Consent Form

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for your Provider to have your current pap and mammogram report prior to your next HRT appointment.

Date: _____

To: _____
Your Doctor's Name

_____
Address

_____
City State Zip

Phone: (___)___-____

Fax: (___)___-____

I, _____, authorize _____
(Your Name) (Your Doctor's Name)

to disclose and release any individually identifiable health information related to me **from the last 2 years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ Mammogram Report Only
- ☐ Pap Report
- ☐ Bone Density
- ☐ Ultrasounds
- ☐ Endometrial Biopsy
- ☐ Any current hormone labs

Are there any restrictions on PHI to be disclosed? Yes No

If yes, please explain: _____

_____

WE DO NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!

Send To: _____
_____
_____
_____
_____
Phone: _____
Fax: _____

_____
Print Name

_____
Date of Birth

_____
Patient Signature

_____
Date