West Valley
Health & Wellness

Low Testosterone				
Personal Information:				
First Name:	Middle:	Last Name:		
Address:	City:	State:	Zip:	
Gender:	Birth Date:	Age:	Last 4 of social:	
Email:	Cell #:	Home #:		
Occupation:	Employer:	May we contact you by: ☐ Cell ☐ Email ☐ Home ☐ Mail		
Current Weight:	Height:			
Emergency Contacts: (please list at least one)				
Name:	Relationship:	Phone #:		
Primary Care:				
Physician Name:	Phone #:	Last Physical:		
How did you hear about us?				
Medical History:				
Are you experiencing any fatigue?	☐ Yes	☐ No	☐ Unsure	
Have you had any muscle weakness or loss of muscle mass?	☐ Yes	☐ No	☐ Unsure	
Has your interest in sex (libido) and/or sexual activity declined?	☐ Yes	☐ No	☐ Unsure	
Do you have spontaneous erections (without medications or other aid)?	☐ Yes	☐ No	☐ Unsure	
Has your energy level or stamina declined?	☐ Yes	☐ No	☐ Unsure	
Have you lost self-confidence, motivation, or initiative?	☐ Yes	☐ No	☐ Unsure	
Have you experienced any decline in memory or concentration?	☐ Yes	☐ No	☐ Unsure	
Have you had sleep disturbances, problems breathing while you are asleep, or increased daytime sleepiness?	☐ Yes	☐ No	☐ Unsure	
Do you have mood swings or depression?	☐ Yes	☐ No	☐ Unsure	
Do you have any nipple tenderness or enlargement?	☐ Yes	☐ No	☐ Unsure	
Have you lost any hair in the genital or underarm areas?	☐ Yes	☐ No	☐ Unsure	
Have you noticed any significant change in your size of your testicles?	☐ Yes	☐ No	☐ Unsure	
Do you have periodic hot flashes or sweats?	☐ Yes	☐ No	☐ Unsure	

Previous Medical History			
Have you ever had a normal PSA test (prostate specific antigen)?	☐ Yes	☐ No	☐ Unsure
Do you now, or have you ever taken, anabolic steroids? If yes, which ones?	☐ Yes	☐ No	☐ Unsure
Have you received testosterone supplementation before? If yes, when? What dose? Results?	☐ Yes	☐ No	☐ Unsure
Have you ever been diagnosed with liver or kidney disease, diabetes, high blood pressure, elevated cholesterol, sleep apnea, prostate issues, or acne as an adult? (If yes, circle which one)	☐ Yes	☐ No	☐ Unsure
Do you have any allergies to medications? If yes, please list below:	☐ Yes	☐ No	☐ Unsure
Do you currently take any prescription medicines, over-the-counter medicines, and/or supplements on a regular basis? If yes, please list:	☐ Yes	☐ No	☐ Unsure
Have you had surgery in your genital area (such as a vasectomy, testicle surgery, or prostate surgery? If yes, what procedure and what year?	☐ Yes	☐ No	☐ Unsure
Are you and our partner/spouse planning to seek pregnancy?	☐ Yes	☐ No	☐ Unsure
Family History			
Are you aware of any blood relatives who have/have had prostate or breast cancer? If yes, please indicate which illness and how the person is related to you:	☐ Yes	☐ No	☐ Unsure

Exercise (frequency and type):			
☐	Never	☐	Endurance (walking, jogging, playing sports, swimming, or climbing hills or stairs)
☐	Once a week	☐	Strength (lifting weights or using resistance bands)
☐	2-4 times a week	☐	Balance (standing on one foot, heel to toe walking, or tai chi)
☐	5-7 times a week	☐	Flexibility (yoga)

Tabacco Intake	
Do you use tabacco?	☐ cigarettes ☐ chew ☐ pipe ☐ cigars
Daily amount use of tabacco and for how long?	
Year you quit?	
Alcohol Intake	
Do you drink alcohol?	
How many drinks per week?	☐ 1-2 ☐ 3-5 ☐ 5-10 ☐ None
What type of alcohol doing usually drink?	
Drug Use	
Do you use street/recreational drugs?	
What type/how often?	
What type of alcohol do you usually drink?	
Caffeine Intake	
Caffeine intake daily	☐ 1-2 cups ☐ 3-5 cups ☐ 5-10 cups ☐ None
What type of caffeine do you drink?	☐ coffee ☐ tea ☐ soda ☐ energy drinks

Testosterone Supplementation Consent to Treatment Plan

Please read and initial beside each statement indicating that you have read, understand, and agree with:

1. This is my consent for West Valley Health & Wellness, including any physician, physician assistant, or nurse practitioner who works with the company, to begin the testosterone supplementation theory. _____

2. It has been explained to me, and I fully understand, that occasionally there are some risks and side effects associated with testosterone supplementation, including the following: Acne, breast enlargement, mood swings, fluid retention, liver or kidney stress, sleep disturbances, prostate enlargement, changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels. _____

3. I understand that I must have blood testing every 3-6 months while receiving treatment. _____

4. I understand that there is no guarantee as to the results of supplementation, and if I stop therapy that symptoms may return or worsen._____

5. I understand that the medical exam performed by the West Valley Health & Wellness provider does not take the place of a full physical exam by my personal physician. _____

6. I agree to have my personal physician perform a yearly full physical exam, including a digital rectal exam to screen for prostate enlargement or cancer. _____

I have had an opportunity to discuss my complete past medical and health history, including any serious problems or issues. All of my questions concerning the risk, benefits, side effects and alternatives, including not receiving treatment of any kind, have been answer to my satisfaction.

Patient Signature _____ Date _____

HIPPA

It is hereby agreed that any and all information, whether written, verbal, literature, protocols or any other communications are considered proprietary and will not be used in any form or shared with any other persons or entities without the expressed written consent of West Valley Health & Wellness. In addition, it is agreed that all patient information is to remain confidential under the guidelines of the Health Insurance Portability Act of 1996.

Patient Signature _____ Date _____

Testosterone Supplementation Consent Form

I confirm that I have had a consultation with West Valley Health & Wellness medical provider (nurse practitioner) whereby the risks, benefits, and possible side effects of hormone supplementation with Testosterone Cypionate have been discussed with, and understood by, me. I have experienced/am experiencing symptoms as indicated by my responses to the new patient questionnaire, as well as the following (please check all that apply):

__ Height loss, low-trauma fracture history, osteopenia, osteoporosis
__ Mild anemia (normocytic/normochromic, c/w female range)
__ Increased body fat, BMI
__ Type II Diabetes Mellitus or Metabolic Syndrome
__ My spouse/partner and I are seeking pregnancy

I understand that the purpose of testosterone supplementation is to improve my energy, exercise endurance, libido, mental focus, and overall well-being. I was given an opportunity to ask the provider questions and they were answered to my satisfaction. _____ Patient Initials _____NP/PA Initials

I am aware that it is my responsibility to have my primary care provider or urologist perform a prostate exam after 6 months of treatment and then annual thereafter. _____ Patient Initials _____NP/PA Initials

I also understand that medicine is not an exact science. Although West Valley Health & Wellness providers will carry out my treatment carefully and per Endocrine Society Guidelines, the possibility that I may experience negative side effects is something I have considered when deciding if testosterone supplementation is right for me. I understand that possible negative side effects of testosterone treatments may include the following:

- Injection site redness, bruising, and/or discomfort
- Irritability or mood swings
- Sleep disturbances, worsening of sleep apnea
- Oily skin and/or acne
- Testicular atrophy and breast tenderness or enlargement
- Decreased sperm production
- Increased blood pressure
- Fluid retention that can cause changes in liver, kidney, and/or heart functions
- Changes in cholesterol, red blood cells, and other hormone levels
- Prostate enlargement, increase in PSA or changes in urinary stream

I understand that these possible side effects are rare and often related to over-supplementation and that the providers at West Valley Health & Wellness intend only to supplement my testosterone to optimal levels. Blood testing will be required in 3 to 6 month intervals to assure that appropriate dosing is achieved.
_____ Patient Initials _____NP/PA Initials

I agree that, while patient of West Valley Health & Wellness, I will not take any type of anabolic steroids, testosterone gels, hormone “boosters”, pro-hormones, or any additional testosterone supplementation not provided by West Valley Health & Wellness providers. If, at any time, the use of these items is discovered, I understand that I will be discharged as a patient and will not be entitled to any refund or reimbursement of program costs. _____ Patient Initials _____NP/PA Initials

West Valley Health & Wellness will not be held liable for my choice to use additional steroid hormones without their knowledge or consent.

Patient Signature _____ Date _____