MD WELLNESS CENTER AND MED SPA

Dr. Srinivasu Kesa, MD
American Board of Obesity Medicine
www.MyTrimMD.com
contact@mytrimmd.com

6822 E 82ND ST. SUITE #300 INDIANAPOLIS IN 46250 317.548.4666 317.650.2501 317.350.0059

Intake Form Men

Personal Information:

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what *Biologically Identical Hormones Replacement with pellets is*?

☐ Yes / ☐ No

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as Blood clots, heart disease, stroke, breast cancer, DVT?

_____

Please discuss and feel free to ask any questions if concerned.

What are your goals for Biologically Identical Hormone Replacement?

_____

_____

_____

Medical History:

Personal History

☐ Blood clots	☐ Benign Prostatic Hyperplasia	☐ Peripheral Vascular Disease
☐ Heart Attack/Heart Failure	☐ Urinary Retention	☐ Breast Cancer
☐ Smoking History	☐ Stroke	☐ Heart Disease
☐ Impaired Liver Function	☐ Thrombophlebitis	☐ Osteoporosis
☐ Transient Ischemic Attacks (TIA)	☐ Obstructive Sleep Apnea	☐ Prostate Cancer
☐ Diabetes	☐ High Blood Pressure	☐ Cancer (type) _____

Cholesterol Serum: _____ Date: _____ Triglycerides: _____ HDL: _____

LDL: _____ Chol/HDL Ratio: _____

Save Now

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Bone density scan results: _____ Date: _____

Current Health Care Provider/s:

_____

_____

To What Degree Do You Experience The Following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating	☐	☐	☐	☐	☐
Insomnia/ Sleep Disturbances	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxious	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Moodiness/Emotional Swings	☐	☐	☐	☐	☐
Weight gain/Bloating	☐	☐	☐	☐	☐
Difficulty Remembering Things	☐	☐	☐	☐	☐
Brain Fog	☐	☐	☐	☐	☐
Dry Hair/Skin	☐	☐	☐	☐	☐
Lack of Sexual Desire	☐	☐	☐	☐	☐
Fatigue/Loss of Energy	☐	☐	☐	☐	☐
Muscle Sagginess	☐	☐	☐	☐	☐
Muscle and/or Joint Pain	☐	☐	☐	☐	☐
Obesity/ overweight	☐	☐	☐	☐	☐
Body hair loss	☐	☐	☐	☐	☐
Sweating/ hot flashes	☐	☐	☐	☐	☐

Please answer Yes or No to the following Questions:	**Yes**	**No**
Did you have incomplete or delayed sexual development?	☐	☐
Are you having decreased libido? I.e., do not get spontaneous erections as before?	☐	☐
Are you having trouble maintaining an erection throughout intercourse?	☐	☐
Are you having breast discomfort and gynecomastia?	☐	☐
Are you having loss of axillary and pubic hair/a reduced need for shaving?	☐	☐

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Do you feel your testicles are smaller or if they have shrunk recently?	☐	☐
Have you had a sperm analysis before?	☐	☐
Do you tend to break bones easily?	☐	☐
Do you have decreased energy, motivation, initiation, and self-confidence?	☐	☐
Have you ever been told that you have a low blood count or mild anemia?	☐	☐
Have you ever had a PSA level done?	☐	☐
Have you had your LH and FSH levels done before?	☐	☐
Have you ever had a history of elevated PSA more than 4?	☐	☐
Are you planning to have children soon?	☐	☐
Are you currently on steroids?	☐	☐
Are you on opiates on a long-term basis?	☐	☐
Are you on anti-seizure medications like Dilantin?	☐	☐
Are you on anti-psychotic medications? For example Haldol	☐	☐
Do you use any recreational drugs like cannabinoids?	☐	☐
Are you currently on methadone?	☐	☐
Are you on any other hormonal treatment?	☐	☐
Have you been diagnosed with any thyroid problems?	☐	☐
Are you on thyroid replacement therapy?	☐	☐
Have you ever had treatment for prostate cancer with drugs like Buserelin?	☐	☐
Do you have recurrent prostate infections in the recent past?	☐	☐
Do you feel you are developing excess wrinkles, aging appearance, extra-abdominal girth?	☐	☐
Do you feel you are more anxious, irritable, and nervous?	☐	☐
Do you feel you are becoming more and more indecisive over time?	☐	☐
Do you worry a lot about your health?	☐	☐
Do you feel you are sadder and cry a lot more than usual?	☐	☐
Do you feel you are not able to work out as much and lack endurance while working out?	☐	☐
Do you feel you are more withdrawn than in the past?	☐	☐

General Health & Lifestyle

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ Do you exercise, describe: _____

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Surgery: **Date of Surgery:**

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications & Reason:

_____

_____

_____

_____

Current Vitamins/Minerals/Herbal Formulas:

_____

_____

_____

_____

Prior Hormone Replacement Therapy History: (Include dates of use)

_____

_____

_____

_____

Known Allergies: (drug, food, pollen)

_____

_____

_____

_____

Do you eat/drink soy: _____ Caffeine/amount per day: _____
Alcohol/amount per day: _____

Notes and/or Questions:

_____

_____

_____

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BHRT Considerations:

BHRT Dosage Form

Would You Like Your Treatment To Be With?

☐ Pellets once every few months.
☐ Topical gel applied once daily to inner arms or thighs
☐ Sublingual tablets dissolved under tongue twice daily

It is recommended that baseline hormone level be checked. This can be achieved by testing blood. We suggest that you test for the following hormones:

☐ a. Thyroid: TSH, T3, and T4
☐ b. Cortisol
☐ c. Testosterone (Free & Total)
☐ d. Progesterone
☐ e. Estradiol and Estrone
☐ f. DHEA (Sulfate)
☐ g. Vitamin D3 (25-Hydroxy)
☐ Optional: Reverse T3 (practitioner discretion)

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Notes And/or Questions:

_____

_____

Waiver & Privacy Information

Waiver

With this release MD Medical Weight Loss and Wellness Center, all its employees and pharmacists from any and all liability whatsoever associated with or connected to my Biologically Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with BHRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination and appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial

infarction, stroke, and breast cancer possibly associated with BHRT use. I have answered all of the questions on this questionnaire truthfully.

Signed _____ **Date** _____

Privacy Agreement:

Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at MD Medical Weight Loss and Wellness Center. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all of our patients receive our Notice of Privacy Practices at the time of, or before, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

To ensure that there will not be a delay on your first prescription from MD Medical Weight Loss and Wellness Center and that you are not provided with prompt service, we ask that you read our Notice of Privacy Practices, sign the Acknowledgement form at the bottom of the page and return to us.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

MD Medical Weight Loss and Wellness Center Indianapolis, IN 46250

_____	_____	_____
Patient Last Name	**Patient First Name**	**M.I.**
_____	_____	_____
Street Address	**City**	**State**
_____	_____	
Zip Code	**Telephone Number**	

My signature below certifies that I have been provided with a copy of the notice mentioned earlier of Privacy Practices.

_____	_____
Patient Signature (or authorized representative)	**Date**