LOW T NATION

LOW T NATION TESTOSTERONE MEN'S INTAKE FORM

NAME: _____ DATE: _____

ADDRESS:_____CITY:_____STATE:_____

ZIP: _____ CELL #: _____ HOME #: _____

SOC SECURITY #: _____ DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

EMAIL ADDRESS: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED ( ) UNDISCLOSED

PATIENTS EMPLOYER: _____ WORK #: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

DRIVER'S LICENSE #: _____ STATE: _____

ADDRESS: _____

CONTACT #: _____ ( ) CELL ( ) HOME

PATIENT SIGNATURE: _____ DATE: _____

Health History Questionnaire:

Patient Name: _____ DOB: _____ Date: _____

Occupation: _____

Primary Care Doctor (PCP): _____ Phone number: _____

Pharmacy Number: _____ Date of last physical exam: _____

Personal Health History

Please circle all that apply:

General	Diabetes	High Cholesterol	Unwanted Weight Loss
Cancer	Personal History of Cancer	Family History of Cancer	Autoimmune Disorder
Cardiovascular	Heart Failure	Heart Attack	Heart Murmur
	Vascular Disease	Blood Clots	Edema
	Hypertension	Irregular Heartbeat	Congestive Heart Failure
Respiratory	Sleep Apnea	Shortness of breath	Asthma / COPD
	Bronchitis	Pneumonia	Allergies
Gastrointestinal	Lactose Intolerance	Gall Bladder	Gall Stones
	Chronic Diarrhea	Chronic Constipation	
Genitourinary	Prostate Cancer	Prostate Cancer in Family	Overactive Bladder
	Painful Urination	Decreased urinary force	On/Off Urine Flow
	Enlarged Prostate (BPH)	Blood in Urine	Kidney/Bladder History
Infection	Kidney /Bladder	Liver	Any Other
Psychiatric	History of Depression	Personality Disorder	Any Other

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers. Please make sure to include any anti-anxiety or anti-depressant medications.

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Allergies: _____ No Known Allergies Or List Allergies and Reaction

_____

_____

Surgeries:

Year _____ Surgery/Reason _____

Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: _____ Sedentary (No exercise) _____ Mild exercise _____ Occasional vigorous exercise _____ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____

_____

_____

Have you used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past? Please be completely truthful with your response, it is critical in order to diagnose and prescribe correctly.

_____

_____

Rate your quality of sleep: 1-Worst 10-Best

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire

Alcohol: ____Yes Number of drinks per week: _____ ____No

Tobacco: ____Yes _____ Cigarettes ____ Cigars ____ Chewing How many/much: _____ ____No

Illicit drug use: ____Yes Explain _____ ____No

Vitals

Blood Pressure _____ Pulse _____ Respiratory Rate _____

Weight _____ Height_____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased concentration ____ Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Moodiness ____ Yes ____ No

Depression ____ Yes ____No

Increasing fatigue ____ Yes ____No

Decreasing energy ____ Yes ____No

Daytime sleepiness ____ Yes ____ No

Poor sleep habits ____ Yes ____No

Erectile dysfunction ____ Yes ____ No

I have had testosterone checked previously _____ Yes ____ No

I have used testosterone previously ____ Yes ____ No

If yes, date(s): _____ Type: _____ Usage: _____

Patient Name (Print) _____DOB: _____

Signature: _____Date: _____

LOW T NATION

ACH Debit Authorization Form

I _____ authorize Low T Nation to charge my credit card for services rendered not to exceed the amount shown.

Date of Birth: _____

Lab Charge Amount: $ _____USD

Monthly Charge Amount: $ _____USD

CREDIT CARD

CARD NUMBER _____

CARD CVC _____

EXPIRATION DATE _____

BILLING ADDRESS _____

_____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____
SIGNATURE DATE

OFFICE USE ONLY

DOB: _____

Cell: _____

Email: _____

LabCorp req#: _____

Consent for Testosterone Replacement/ hCG Therapy/ No Other Therapy Agreement

Patient Name: _____ DOB: _____

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT/hCG THERAPY (TRT)

It is important to understand that all medicine is an inexact science. Although we will carry out your treatment carefully, results may vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider. Please review the following statements, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all your questions to your satisfaction.

Directions: Initial beside each statement that you have read, understand and agree with.

_____1. This is my consent LOW T NATION, LLC., including any physician or nurse who works with the company, to begin my treatment for Testosterone Replacement Therapy.

_____2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3-#7)

_____3. Extra fluid in the body- This can cause problems for patients with heart, kidney or liver disease.

_____4. Sleep disturbance - This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.

_____5. Prostate enlargement- this may cause problems with urinating.

_____6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____7. I understand that I will have periodic blood tests to monitor my blood levels.

_____8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____9. I have had an opportunity to discuss with LOW T NATION, LLC. and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers.

_____10. I understand that the physical exam by LOW T NATION, LLC. does NOT replace a full physical exam by a personal physician.

_____11. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician, LOW T NATION, LLC. will assist in locating one for me.

_____12. Family Planning for the patient has been discussed.

_____13. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility.

_____ 14. I have been trained on how to administer intramuscular and subcutaneous injections from a licensed medical practitioner who is approved to perform such tasks.

I, _____, agree that, while a patient of LOW T NATION, LLC., I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by LOW T NATION, LLC. during my treatment plan. At any time, if use of these items is discovered, I understand I will be discharged as a patient of LOW T NATION, LLC..

Patient Signature _____ Date _____

Witness Signature _____ Date _____

NOTES:

Notes: