COMPASS HEALTHCARE

HORMONE REPLACEMENT THERAPY
MALE MEDICAL HISTORY

NAME: _____ DOB: _____

PHONE NUMBER: _____

1. Are you currently taking a Testosterone Replacement Product? Yes ____ No ___

If yes, please list name and dosage amount: _____

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2. Have you been on Testosterone Replacement in the past year? Yes ____ No ____

If yes, please list name and date when last taken: _____

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3. Have you had a Prostatectomy? Yes ____ No ____

If yes, please list date: _____

4. Do you have a family history of Breast, Ovarian, Colon or Pancreatic Cancer?

Yes ____ No ____ If Yes, please list who and at what age they were diagnosed with Cancer: _____

SYMPTOMS:	**YES**	**NO**
Erectile Dysfunction	_____	_____
Decreased Libido (Sex Drive)	_____	_____
Decreased Self-Confidence	_____	_____
Low Motivation	_____	_____
Fatigue/Decreased Energy	_____	_____

SYMPTOMS: (cont'd)	**YES**	**NO**
Depression	____	____
Anxiety	____	____
Irritability	____	____
Decline in Well-Being	____	____
Joint Pain/ Muscle Loss	____	____
Excessive Sweating	____	____
Breast Development	____	____
Shrinking Testicles	____	____
Rapid Hair Loss	____	____
Trouble Sleeping/Insomnia	____	____
Brain Fog/Decreased Mental Clarity	____	____
Loss of Memory/Trouble Concentrating	____	____
Weight Gain/Increased Body Fat	____	____
Bone Loss/Decreased Bone Density	____	____
Decreased Muscle Mass/Strength	____	____
Harder to Build/Maintain Muscle	____	____
Decreased Exercise Tolerance/Longer Recovery Time	____	____
New Migraine Headaches	____	____
Decreased Morning Erections	____	____
Decreased Ability to Perform Sexually	____	____
No Results from E.D. Medications	____	____
Exhaustion/Lacking Vitality	____	____
Feeling Burned Out/Hit Rock Bottom	____	____

Please list other symptoms you have that concern you: _____

_____

5. Have you had a Vasectomy? Yes ____ No ____

6. Are you trying to conceive? Yes ____ No ____

7. Do you currently have or had within the past 12 months:

_____ Bladder Infection
_____ Enlarged Prostate
_____ Blood in Urine
_____ Prostate Cancer (Ever Had)
_____ Prostate Infection
_____ Kidney Infection
_____ Testicle Cancer (Ever Had)

COMPASS HEALTHCARE

TESTOSTERONE REPLACEMENT THERAPY (TRT) – INFORMED CONSENT FORM
Patient Name: _____
Date of Birth: _____
Date: _____

1. Purpose of Treatment
Testosterone Replacement Therapy (TRT) is prescribed to treat symptoms of testosterone deficiency (hypogonadism), such as fatigue, low libido, mood changes, and decreased muscle mass or bone density. The goal is to restore testosterone levels to a normal physiological range.

2. Treatment Options
TRT can be administered in several forms, including:

- Injections (e.g., testosterone cypionate or enanthate)
- Transdermal patches or gels
- Implantable pellets
- Oral or buccal formulations

Your provider will recommend the most suitable method based on your needs and preferences.

3. Potential Benefits

- Improved energy and mood
- Increased libido and sexual function
- Improved muscle mass and strength
- Enhanced mental clarity and focus
- Maintenance of bone density

4. Potential Risks and Side Effects
TRT may include, but is not limited to, the following risks:

- Acne or oily skin
- Increased red blood cell count (polycythemia)
- Sleep apnea or worsening of existing apnea
- Enlargement of the prostate or worsening of benign prostatic hyperplasia (BPH)
- Reduced fertility and testicular shrinkage
- Breast enlargement (gynecomastia)
- Possible increased risk of cardiovascular events (still under study)

Regular monitoring (blood tests, PSA, hematocrit, etc.) is required during treatment.

5. Contraindications and Cautions
TRT may not be appropriate for individuals with:

- Prostate or breast cancer
- Severe untreated sleep apnea
- Uncontrolled heart failure
- Elevated red blood cell counts
- Active liver disease

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6. Monitoring and Follow-Up
I understand that I will need:

- Regular blood tests to monitor hormone levels, hematocrit, liver function, PSA (prostate-specific antigen), and lipid profile
- Periodic physical exams to monitor for side effects
- To notify my provider of any changes in symptoms, side effects, or medical history

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7. Alternatives
I understand that alternatives include:

- No treatment, with ongoing observation
- Lifestyle changes (diet, exercise, sleep)
- Treating underlying causes of low testosterone
- Other medications or therapies

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8. Patient Acknowledgment and Consent
I certify that I have:

- Read and fully understand this consent form
- Had the opportunity to ask questions, and all questions have been answered
- Been informed of the potential risks, benefits, and alternatives
- Voluntarily consent to TRT and agree to follow the recommended monitoring plan

Patient Signature: _____ Date: _____
Provider Name: _____
Provider Signature: _____ Date: _____