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Female Hormone Replacement Targeted History

Are you in menopause? ☐Yes ☐No

If not, date of last menstrual period: _____

If not, please indicate your birth control method: _____

Do you have a uterus? ☐Yes ☐No

Are you taking any hormones now? ☐Yes ☐No

If yes, list the hormones: _____

Have you taken hormones in the past? ☐Yes ☐No

Do you have any nervous feelings, fears, sensitivities, or concerns about taking hormones? ☐Yes ☐No

Have you had breast cancer or a lump? ☐Yes ☐No

If yes, please explain: _____

Have you had any DVTs (blood clots in leg), stroke, or heart attack? ☐Yes ☐No

If yes, please provide some details: _____

Do you have psychiatric conditions or take medications to control your moods? ☐Yes ☐No

If yes, please indicate which psychiatric conditions and/or medications:

_____

Do you have any allergies to anesthetics, iodine, hormones, or Latex? ☐Yes ☐No

If yes, please list: _____

Do you have any autoimmune disorders like lupus, vasculitis, diabetes, multiple sclerosis, or rheumatoid arthritis? ☐Yes ☐No

If yes, please indicate which one: _____

Do you use recreational drugs, medications for sleep, or routine use of pain meds? ☐Yes ☐No

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Are you taking aspirin, NSAIDs, blood thinners,
or being treated for coagulation? ☐Yes ☐No

Date of your last:

Pelvic Ultrasound: Date: _____

Mammogram: Date: _____

Pap Smear: Date: _____

Menopause Rating Scale

(0=None; 1=Mild; 2=Moderate, 3=Severe, 4=Very Severe)

Hot flushes, sweating:	☐0	☐1	☐2	☐3	☐4
Heart discomfort (skipping, racing, tightness):	☐0	☐1	☐2	☐3	☐4
Sleeping problems (difficulty falling asleep, not sleeping through, waking up early):	☐0	☐1	☐2	☐3	☐4
Depressed Mood (feeling sad, on the verge of tears, lack of drive, mood swings):	☐0	☐1	☐2	☐3	☐4
Irritability (feeling nervous, inner tension, feeling aggressive):	☐0	☐1	☐2	☐3	☐4
Anxiety (inner restlessness, feeling panicky):	☐0	☐1	☐2	☐3	☐4
Physical and mental exhaustion:	☐0	☐1	☐2	☐3	☐4
Sexual Problems (change in desire, activity, and satisfaction):	☐0	☐1	☐2	☐3	☐4
Bladder Problems (increased need to urinate and incontinence):	☐0	☐1	☐2	☐3	☐4
Vaginal Dryness:	☐0	☐1	☐2	☐3	☐4
Joint and muscular discomfort (pain in joints, rheumatoid complaints):	☐0	☐1	☐2	☐3	☐4

Total Sum of Scores: _____

*Highest symptomatic score is 44; the lower the score, the better. *

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Female Patient Bloodwork Form

Patient Name: _____ Date of Birth: _____

Fasting: ☐ Yes ☐ No

☐Pre-Insertion Labs	☐Post-Insertion Labs
• Estradiol* • Total & Free Testosterone* • FSH • Progesterone • Lipid Panel • Comprehensive Metabolic Panel • DHEA • TSH • Free T4 & T3 • Complete Blood Count	• FSH • Estradiol* • Total & Free Testosterone* • DHEA • Complete Blood Count*

*If testosterone and/or estradiol levels are greater than 300, repeat levels prior to next insertion.

Note: Continue testing levels after each insertion, until the patient feels great, then only once a year.

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Female Pellet Insertion Consent

General: Bio-identical hormone pellets are naturally derived concentrated hormones in a compressed form, which are biologically identical to an individual's naturally occurring hormones. These have been successfully used since the 1930s and provide a longer acting alternative to other hormone combinations such as tablets, patches, creams, or injections.

Benefits: Potential benefits can include decreased frequency and severity of menopausal symptoms, such as hot flashes, night sweats, headaches, mood swings, anxiety, increase in muscle mass, and decrease in subcutaneous fat.

Side Effects: Hormone related side effects and risks are generally applicable to the use of hormones, regardless of the mode of delivery. These may include irregular bleeding, breast tenderness, swelling, increase in hair growth, water retention, increased growth of estrogen dependent tumors, blood clots, liver tumors, and acne. Procedure related complications may include infection, bleeding, bruising, swelling, pain, extrusion, or scarring. Surgical risks are the same as for any minor medical procedure and include those described above.

Contraindications: Potential contraindications include pregnancy, undiagnosed abnormal vaginal bleeding, active thromboembolic disorder, myocardial infarction, breast or endometrial cancer, or liver disease. Each woman will be evaluated to determine appropriateness for hormone therapy prior to hormone pellet therapy. As with all hormone replacement therapy strategies, patients who are not sterilized and not menopausal are strongly advised to continue reliable birth control while participating in pellet hormonal replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

Minimizing risk: An important part of minimizing potential complications is understanding risk. This will be done by getting baseline labs and doing a simple physical exam. These will include mammogram, gynecologic exam and pap if indicated, CBC, metabolic panel, and hormone levels. These will be repeated annually. As you continue to use hormone therapy it will be important to keep your provider aware of any changes that may affect your response to hormones. This may include a new diagnosis, or a change in your medications, or even plans for surgery. If your plans for fertility change, you will likely need to stop hormone replacement therapy. Additionally, studies have shown that when women are physically active, eat a healthy diet, and maintain normal weight, they can minimize their risks further.

CONSENT FOR TREATMENT: I have read and understand the above. I have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of hormone therapy that we do not know at this time. I understand the risks and benefits of this treatment. I have been informed that I may experience complications from infection, extrusions, or that I may note no effect or otherwise be dissatisfied with my treatment. If these do occur, my provider will provide care to address the complication at no cost, and if appropriate, discount or reimburse me for my pellets up to 50% of my cost. I agree to report to my provider any adverse reaction or problems that may be related to my therapy, so any issues can be addressed in a timely manner and minimize any potential complications or adverse reactions.

I understand that payment is due in full at the time of service. My signature certifies that I have read and understood the above.

Patient Name: _____ Signature: _____

Date: _____

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Pre-Pellet Insertion CHG (Chlorhexidine Gluconate) Body Cleansing

Getting your skin ready for surgery is extremely important! To do this, one must cleanse your skin with CHG. This is a special chemical found in soaps, such as Hibiclens and other brands.

First, purchase the 4% Hibiclens at any pharmacy. Second, gather clean, freshly laundered washcloths, towels, and clothes for each shower. For the best results, bathe 1 day prior to surgery and the morning of surgery.

Before using, read all the instructions below:

1. Wash and rinse your hair, face, and body using your normal shampoo and soap.
2. Make sure you completely rinse off in a very thorough manner.
3. Turn off the shower, or step out of the bathwater.
4. Pour a quarter size amount of liquid CHG/Hibiclens soap onto a wet, clean washcloth, and apply to your entire body from the neck down. Do NOT use on your face, hair, or genital areas.
5. Rub the soap filled washcloth over your entire body for 3 minutes; apply more soap as needed (1/4 of bottle should be used with each of the showers/cleansing). Avoid scrubbing your skin too hard.
6. Turn on the shower or return to the bath and rinse the soap off your body completely with warm water.
7. Do NOT use regular soap after washing with the Hibiclens.
8. Pat your skin dry with a freshly laundered, clean towel after each shower/bath cleansing.
9. Dress with freshly laundered clothes after each shower/bath cleansing.
10. The night before surgery sleep with clean bed linens.
11. Do NOT apply any lotions, deodorants, powders, or perfumes to your body.
12. Do NOT shave your legs the night before or the day of surgery, nor remove any body hair below the neck. Facial shaving is the only thing permitted before surgery.
13. Throughout this process, good hand hygiene is a must, every day. Throughout the entire day, wash hands with soap and water to ensure adequate cleansing.

If an allergic reaction occurs, stop using the CHG/Hibiclens soap.

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Post-Insertion Instructions

Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. The inner layer should be removed after 3-5 days.

We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4-5 hours.

Do not take tub bath or get into a hot tub or swimming pool for 3 days. You may shower, but do not scrub the site until the incision is well healed (about 7 days).

No major exercises for the incision area for the next 3 days. This includes running, elliptical, squats, lunges, etc.

The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.

The insertion site may be uncomfortable for up to 2-3 weeks. If there is itching or redness, you may take Benadryl 50mg orally every 6 hours. This can cause drowsiness. You can also try Zyrtec or Claritin during the day if preferred.

You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2-3 weeks.

You may notice some pinkish or bloody discoloration on the outer bandage; this is normal.

If you experience bleeding from the incision, apply firm pressure for 5 minutes. Please call if you have bleeding not relieved with pressure (not oozing), as this is NOT normal.

Please call if you have any pus coming out of the insertion site, as this is NOT normal and could indicate an infection.

Reminders:

Remember to go for your post insertion blood work **6 weeks** after the insertion.

Most women need a re-insertion of their pellets at 3-4 months, and men need a re-insertion at about 4-5 months.

Please call as soon as the symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion.

Additional instructions: _____

_____

I acknowledge that I received a copy and understand the instructions on this form.

Patient Signature: _____ Date: _____