



4510 Medical Center Dr. Suite 314
McKinney, Texas 75069
☎ 214-237-4132
📠 214-237-4130
info@empowerwla.com
www.empowerwla.com
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1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Today's Date _____

Date of Birth: _____ Age: _____ Occupation: _____

Weight: _____ Marital Status:
 Married Divorced Widow
 Living with Partner Single

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
 Mobile Phone Home Phone Work Phone
 Email

May we contact you via E-mail?
 Yes No

In case of Emergency Contact: _____ Emergency Contact Phone Number: _____

Primary Care Physician's Name and phone number: _____ Primary Physician Address: _____

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name or Significant Other _____ Relationship _____

Home Phone Number: _____ Cell Phone: _____

Work Phone: _____

2. Social:

- I am sexually active. I have completed my family I have used steroids in the past for athletic purposes
- I want to be sexually active.

3. Habits:

	How much?	How often?
Smoking- cigarettes/cigar		
Alcohol		
Recreational drugs		
Tea		
Coffee		

4. Any known drug allergies:

5. Have you ever had any issues with anesthesia?

- Yes
 No

If yes, please explain

6. Please list any prescribed medications you take:

	Name	Dosage
1		
2		

7. Current Hormone Replacement Therapy:

8. Past Hormone Replacement Therapy:

9. Please list any nutritional/vitamin supplements you currently take:

	Name of supplement	Dosage
1		
2		

10. Surgeries, list all and when:

11. Other pertinent information:

12. Medical Illnesses: Please tick the boxes which indicate conditions you have had or presently have. If any other conditions, please list them on the box down below:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clot |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Bypass |
| <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Liver Disease (hepatitis, fatty liver, cirrhosis) | <input type="checkbox"/> Mood disorder |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Pulmonary Emboli | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart |
| <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> No medical Problems |

If cancer: Type and Year

13. Family History: Please tick any family history listed below:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Breast Cancer | |

Please explain:

14. How did you hear about our clinic?

- Internet Search Yelp Family/Friend
 BioTE website Facebook Other

15. Please Answer Below:

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive Sweating				
Sleep Problems				
Increased Need for Sleep				
Irritability				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion/lacking vitality				
Declining Mental Ability to Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased Muscle Strength				
Weight Gain/Belly Fat/Inability to lose weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No results from E.D. medications				

I understand that if I begin testosterone replacement with any testosterone treatment, including pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone pellets should be out of your system in 12 months. By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Signature

Date