Testosterone Replacement Therapy (TRT) – Patient Consent Form
Clinic Name: _____
Patient Name: _____
Date of Birth: ___ / ___ / _____
Date: ____ / ____ / _____

Purpose of TRT

The purpose of Testosterone Replacement Therapy (TRT) is to treat symptoms of low testosterone (hypogonadism), which may include fatigue, decreased libido, mood changes, difficulty building muscle, and other related concerns. TRT involves administering testosterone through injections, topical gels, pellets, or other prescribed methods to restore testosterone levels to the optimal range.

Potential Benefits

While individual results vary, potential benefits of TRT may include:

- Improved energy levels
- Increased libido and sexual function
- Enhanced mood and sense of well-being
- Increased lean muscle mass and decreased body fat
- Improved bone density

Risks and Potential Side Effects

I understand that TRT carries possible risks, which include but are not limited to:

- Acne or oily skin
- Increased red blood cell count (polycythemia), which may increase clotting risk
- Swelling in ankles or feet
- Mood changes or irritability
- Sleep apnea or worsening of existing sleep apnea
- Gynecomastia (breast tissue enlargement)
- Testicular shrinkage and reduced sperm production, potentially affecting fertility
- Increase in prostate-specific antigen (PSA) levels and possible prostate enlargement
- Cardiovascular risks, including heart attack or stroke (especially in patients with pre-existing cardiovascular disease)

Monitoring Requirements

I understand that ongoing medical monitoring is essential while on TRT and agree to:

- Complete **regular blood work** as ordered (typically every 3–6 months) to monitor testosterone levels, estradiol, complete blood count (CBC), PSA, and other relevant labs.
- Attend **scheduled follow-up visits** for medical evaluation.
- Immediately report any unusual symptoms, including shortness of breath, chest pain, leg swelling, severe headaches, or changes in urination.

Alternatives to TRT

I understand that alternatives to TRT exist, including:

- No medical treatment and continued monitoring of symptoms
- Lifestyle modifications (diet, exercise, stress reduction, sleep optimization)
- Other pharmacologic or hormonal therapies as appropriate

Patient Responsibilities

- Take TRT medication **exactly as prescribed.**
- Not share medication with others.
- Store medication safely and out of reach of children.
- Report any side effects promptly.
- Follow recommendations for blood donation if hematocrit levels become elevated.

Acknowledgment of Understanding

I have discussed the risks, benefits, and alternatives of TRT with my provider. I understand that results may vary and there is no guarantee of specific outcomes. I have had all my questions answered to my satisfaction and consent to begin or continue testosterone replacement therapy under the care of this clinic.

Patient Signature: _____ **Date:** ____ / ____ / _____

Provider Name (Print): _____

Provider Signature: _____ **Date:** ____ / ____ / _____

Last Name: _____ First Name: _____ M: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender at Birth: ☐ Male ☐ Female

Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian or Pacific Islander ☐ White ☐ Other Race: _____

Address: _____

City, State/ Zip Code: _____

Name of Insurance: _____

Preferred Pharmacy: _____

Preferred method of contact: ☐ E-mail ☐ Text May we send you a text reminder the day before your appointment? ☐ Yes ☐ No

E-mail: _____

Home Phone: _____ Cell Phone: _____

Have you experienced the following Primary Symptoms?

- ☐ Decreased Libido
- ☐ Decreased Spontaneous Erection
- ☐ Breast Discomfort
- ☐ Gynecomastia
- ☐ Testes that are less than 2.5cm in length
- ☐ Unusual Sweating
- ☐ Decrease in Testicular Size
- ☐ Hot Flashes
- ☐ Loss of Axillary or Pubic Hair

Have you experienced the following Secondary Symptoms?

- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Muscle Mass
- ☐ Deterioration of Work Performance
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Strength/Energy
- ☐ Sad, Grumpy or Moody
- ☐ Problems with Memory/Concentration

Do you have or have you had any of the following:

☐ Prostate or Breast Cancer ☐ Uncontrolled Heart Failure or Uncontrolled Blood Pressure ☐ Stroke

☐ Heart Attack ☐ Blood Clot in Legs, Arms, or Lungs ☐ Sleep Apnea w/o CPAP Use ☐ Desire Fertility

Have you been on testosterone or been exposed to testosterone previously? ☐ Yes ☐ No

PLEASE PLACE A CHECK IN THE BOXES, IN RELATION TO YOUR HISTORY AND SYMPTOMS

Chief Complaint / Reason for Visit:

☐ Fatigue ☐ Decreased Sex Drive (Low Libido) ☐ Erectile Dysfunction ☐ Decreased Muscle Mass ☐ Weight Concerns ☐ Mood Concerns

Symptoms began: _____ months / years ago.

Severity of Symptoms: Mild Mild to Moderate Moderate Severe

Any Modifying Factors: _____ Timing of Symptoms: _____

Patient Health History

Have you had Comprehensive physical exam within the last 12 months? ☐ Yes ☐ No
Have you had an EKG in the last 12 months? ☐ Yes ☐ No
If Yes, was it normal? ☐ Yes ☐ No

Have you had a prostate exam in the last 12 months? ☐ Yes ☐ No
If Yes, was it normal? ☐ Yes ☐ No

Allergies to Medications

Medication Name	Reaction

Prescribed Medications & Over-the-Counter Drugs, Dietary Supplements (including vitamins, inhalers, etc.)

Medication Name	Strength	Frequency

Medical History

Check which of these symptoms, disorders, conditions, or illnesses pertain to your history
This includes medical conditions you take or have taken medications for or if you have been diagnosed previously

History of Cardiac Disorder / Event ☐ Negative

- ☐ Myocardial Infarction (Heart Attack)
- ☐ Cerebrovascular Accident (Stroke, Mini-stroke/TIA, Hemorrhage)
- ☐ Thrombosis / Embolism (Blood Clot)
- ☐ Coronary Artery Bypass Graft Surgery (CABG)
- ☐ Aortic Valve Disorder or Replacement
- ☐ Mitral Valve Disorder or Replacement
- ☐ Endocarditis/Pericarditis
- ☐ Cardiomyopathy (Enlarged Heart)
- ☐ Cardiac Conduction Disorder (AV Block, Bundle Branch Block)
- ☐ Cardiac Arrhythmia (Atrial Fib/Flutter, Tachycardia)
- ☐ Heart Failure (Congestive Heart Failure)
- ☐ Pacemaker/Defibrillator Placement

Past Medical History ☐ Negative

- ☐ Prior Hormone Replacement Therapy
- ☐ Sleep Apnea ☐ CPAP in Use
- ☐ Snoring
- ☐ Chronic Kidney Disease
- ☐ Abnormal Liver Function
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Artery Disease
- ☐ Chronic Lymph Node Enlargement
- ☐ Hypogonadism
- ☐ Inability to impregnate despite unprotected sex >1 year
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Enlarged Thyroid
- ☐ Depression
- ☐ Anxiety
- ☐ HIV
- ☐ Mumps
- ☐ COPD/Emphysema
- ☐ Insomnia/Sleep Disorder (includes Shift Work Sleep Disorder
- ☐ Seizures
- ☐ Headaches (Frequent)
- ☐ Anemia
- ☐ Excess Iron Buildup
- ☐ Bleeding Disorder
- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Cancer
- ☐ Cardiovascular Disease
  - ☐ Blood Clot (DVT/Pulmonary Embolism)
  - ☐ Chest Pain
  - ☐ Heart Attack
  - ☐ Heart Failure (CHF)
  - ☐ Stroke or TIA
- ☐ Acid Reflux
- ☐ Gout
- ☐ Obesity
- ☐ Cottonseed Allergy
- ☐ Neuropathy in Extremities
- ☐ Pain in Extremities
- ☐ Excessive Sweating
- ☐ Lack of Sweating
- ☐ Blurry Vision
- ☐ Irritable Bowel Syndrome
- ☐ Frequent Urination
- ☐ Dizziness with Standing
- ☐ Blueish Fingers/Toes when Cold
- ☐ Neuro-degenerative Disease (Parkinson's, Alzheimer's, ALS)
- ☐ Other: _____
- ☐ Other: _____

Past Surgical History ☐ No History of Genitourinary Surgery

- ☐ Vasectomy
- ☐ Other urinary system surgeries: _____
- ☐ Other surgeries: _____

Family History ☐ Negative

☐ Family History of Prostate Cancer
- ☐ First Degree Relative: _____

☐ Family History of Cardiovascular Disease
- ☐ Heart Attack ☐ Stroke

☐ Family History of Endocrine Disease
- ☐ Diabetes ☐ Hypothyroidism ☐ Delayed Puberty ☐ Reproductive Disorder

☐ Family History of Breast Cancer

☐ Family History of Ovarian cancer

☐ Other

Social History

Exercise

How often are you physically active for 20 minutes or longer?

☐ Never ☐ 1-2x/ week ☐ 3-4x/ week ☐ >5x/ week

Which type(s) of exercise do you do? (check all that apply)

☐ Walking ☐ Running ☐ Weights ☐ Other: _____

Do you have any barriers that limit your ability to safely exercise? ☐ Yes ☐ No

Please check all that apply:

☐ Work ☐ Family ☐ Energy Level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other: _____

Caffeine

Rank your caffeine intake: ☐ High ☐ Medium ☐ Low ☐ None

What do typically drink during the day?

☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other: _____

How many cups/cans per day? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ☐ Beer ☐ Liquor ☐ Wine

How many drinks per week? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks/day: _____ ☐ Other: _____ How many years? _____

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex

Are you sexually active? ☐ Yes ☐ No

If yes, are you trying for a pregnancy? ☐ Yes ☐ No

Do you desire more children? ☐ Yes ☐ No

If not trying for a pregnancy, list contraceptive or barrier method are you using:

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

How many meals do you eat on an average day?

Rank your salt intake: ☐ High ☐ Medium ☐ Low

Rank your fat intake: ☐ High ☐ Medium ☐ Low

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation:

Review of Symptoms

Check which of these symptoms are troublesome and have persisted over time

Androgen Deficiency

Primary Symptoms

- ☐ Decreased Sexual Desire (Low Libido)
- ☐ Decreased Spontaneous Erections
- ☐ Breast Discomfort
- ☐ Gynecomastia
- ☐ Testes Less Than 2.5cm in Length
- ☐ Unusual Sweating
- ☐ Noticeable Decreased in Testicular Size
- ☐ Hot Flashes
- ☐ Loss of Axillary or Pubic Hair

Secondary Symptoms

- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Muscle Mass
- ☐ Recent Deterioration of Work Performance
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Strength/Energy
- ☐ Sad, Grumpy or Moodiness
- ☐ Problem with Memory/Concentration

Thyroid

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice Hoarseness	☐ Constipation
☐ Heart Palpitations	☐ Fatigued/Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

Sexual Function

☐ Loss Morning Erections	☐ Loss of Spontaneous Erections	☐ Trouble Getting an Erection
☐ Trouble Keeping an Erection	☐ Decreased Sexual Desire (Low Libido)	☐ Premature Ejaculation
☐ Delayed Ejaculation		

Nervous System

- ☐ Heat Intolerance
- ☐ Numbness/Tingling in Extremities
- ☐ Excessive Sweating
- ☐ Lack of Sweating
- ☐ Tremors/Shakiness
- ☐ Frequent Urination/Inability to Control Bladder
- ☐ Nervousness/Anxiety/Stress
- ☐ Dizziness with Standing
- ☐ Swelling in Extremities
- ☐ Blueish Fingers/Toes when Cold
- ☐ Extreme Irritability/Anger/Tension
- ☐ Blurry Vision
- ☐ Inappropriate Weight Loss
- ☐ Exercise Intolerance
- ☐ Pain in Extremities

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____