Metro Medispa
AGE MANAGEMENT & REJUVENATION

Bio-Identical Hormone Replacement Therapy

Confidential Medical History

Name_____Date_____Height_____Weight_____

Address_____Date of Birth_____Age_____Sex_____

City_____State_____Zip_____Phone Number_____

Driver's License Number_____Email_____

Primary Physician_____Phone Number_____

Allergies	**Yes**	**No**
Penicillin	__	__
Codeine	__	__
Sulfa Drug	__	__
Morphine	__	__
Aspirin	__	__
Food Allergies	__	__
Dye Allergies	__	__
Nitrate Allergies	__	__
No Known Allergies	__	__
Pet Allergies	__	__
Seasonal	__	__
Other_____		

Used	**How Often?**
Tobacco	_____
Alcohol	_____
Caffeine	_____

Over the Counter Issues:	**Yes**	**No**
Pain Reliever	__	__
Aspirin	__	__
Acetaminophen	__	__
Ibuprofen	__	__
Naproxen	__	__
Ketoprofen	__	__
Cough Suppressant	__	__
Antihistamine products	__	__
Decongestant products	__	__
Sleep Aids	__	__
Antidiarrheal	__	__
Laxatives	__	__
Diet Aids	__	__
Antacids	__	__
Acid Blockers	__	__
Other_____		

Medical Conditions:	**Yes**	**No**
Heart Disease	__	__
High Cholesterol	__	__
High Blood Pressure	__	__
Cancer	__	__
Ulcers	__	__
Thyroid Disease	__	__
Hormonal Related Issues	__	__
Blood Clotting Problems	__	__
Lung Condition	__	__
Diabetes	__	__
Arthritis or Joint issues	__	__
Depression	__	__
Epilepsy	__	__
Headaches/migraines	__	__
Eye Disease	__	__
Other_____		

Current Medications/Vitamins/Supplements	**Strength**	**Date Started**	**Dosage Per Day**
1._____			
2._____			
3._____			
4._____			
5._____			
6._____			

Women Only:

Have you ever had what you consider an abnormal period cycle?

If so when, and explain? _____

Date of last period? _____

Do you have or did you ever have PMS?

If yes, please explain_____

Have you, your parents, siblings or grandparents ever been diagnosed as having any of the following conditions?

	Yes	No	Family Member
Uterine Cancer	__	__	_____
Ovarian Cancer	__	__	_____
Fibrocystic Breast	__	__	_____
Breast Cancer	__	__	_____
Heart Disease	__	__	_____
Osteoporosis	__	__	_____
	Yes	**No**	**Date**
Hysterectomy	__	__	_____
Ovaries Removed	__	__	_____
Tubal Ligation	__	__	_____
	Yes	**No**	**How Many?**
Pregnancies	__	__	_____
Miscarriages	__	__	_____

Have you ever used contraceptives? Yes__No__

Any Problems?_____

Have you had any of these tests?

Mammography? Yes__No__

Date_____

Pap Smear? Yes__No__

Date_____

Bone Size:

Small__Medium__ Large__

Bone Type:

Androgenic__Estrogenic__

Have you experienced any of the following symptoms recently? Please check the number that best describes your experience. 1=Absent, 2=Mild, 3=Moderate, 4= Severe

	1	2	3	4
Sleep Disruptions	__	__	__	__
Fatigue	__	__	__	__
Vaginal Dryness	__	__	__	__
Irritability	__	__	__	__
Nervousness	__	__	__	__
Breast Tenderness	__	__	__	__
Hot Flashes	__	__	__	__
Dry Skin	__	__	__	__
Mood Swings	__	__	__	__
Arthritis	__	__	__	__
Loss or Recent Memory	__	__	__	__
Weight Gain	__	__	__	__
Decreased Libido	__	__	__	__
Depression	__	__	__	__
Fluid Retention	__	__	__	__
Headaches	__	__	__	__
Night Sweats	__	__	__	__
Hair Loss	__	__	__	__
Hard to Reach Climax	__	__	__	__
Bladder Symptoms	__	__	__	__
Other:	__	__	__	__

Have you ever had a history of substance abuse? ____ Yes ____ No If yes, please explain.

Have you ever been on testosterone in past? ____ Yes ____ No If yes, please explain.

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Do you have Growth Hormone Deficiency?

Please assess your current state of health by checking the description that best suits your experience in all of the following areas.

Muscle Tone	Not at all	Slight	Moderate	Significant	Extreme
Reduced Muscle Mass	__	__	__	__	__
Reduced Muscle Strength	__	__	__	__	__
Reduced Exercise Performance	__	__	__	__	__
Increased Body Fat	__	__	__	__	__
Lipids					
Elevated LDL Cholesterol	__	__	__	__	__
Reduced Bone Density	__	__	__	__	__
Bone					
Reduced Bone Density	__	__	__	__	__
Metabolism					
Blood Sugar Abnormalities (hypoglycemia or diabetes)	__	__	__	__	__
Reduced Thyroid Function	__	__	__	__	__
Hair and Skin					
Thinning of Skin	__	__	__	__	__
Wrinkles	__	__	__	__	__
Decreased Hair and Nail Growth	__	__	__	__	__
Mental Health					
Reduced Energy	__	__	__	__	__
Reduced Memory and Concentration	__	__	__	__	__
Depression	__	__	__	__	__
Emotional Instability	__	__	__	__	__
Reduced Quality of Sleep	__	__	__	__	__
Healing and Immunity					
Increased Healing Time	__	__	__	__	__
Decreased Flexibility	__	__	__	__	__
Chronic Pain (ex. Arthritis)	__	__	__	__	__
Increased Susceptibility to Illness	__	__	__	__	__
Sexual Function					
Reduced Sex Drive	__	__	__	__	__
Reduced Sexual Potency	__	__	__	__	__

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Consent to Treatment

The Nature of the Treatment: I hereby give my consent to evaluation and treatment intended to slow the aging process and/or reverse the symptoms of aging by the administration of hormone replacement therapy and/or nutritional supplements including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels. The nature of the procedure is to raise levels of hormones in by body to levels in the upper normal range for younger adults in the 25-35-year age bracket. Regarding the nutritional supplements, the goal is to raise levels of vitamins. Minerals and anti-oxidants in order to maximize the physiologic processes in my body and minimize damage by naturally produced free radicals.

Alternative Treatment Methods and Their General Nature:

The reasonable alternative to this treatment have been explained to me and they include:

The General Nature and Extent of Treatment-Related Risks:

I appreciate that there are certain risks associated with this procedure, which may occur in up to 10% of the population. These risks include water retention, which may result in leg swelling, elevated blood pressure, which may be reversed with dose adjustment, mild increase in fasting blood sugar and occasional bruises at the injection site. I may also develop infection at the injection site if I use improper technique. Other possible side effects including breast swelling and/or discomfort for women and testicular atrophy (shrinking) for men. These side effects are reversible by dosage adjustment or stopping therapy.

I understand that contraindications (reasons to avoid) the use of Human Growth Hormone are: the presence of a cancer or tumor; uncontrolled diabetes; unusual lung diseases such as pulmonary fibrosis: pneumoconiosis, bronchiolitis, obliterans, Hermansky-Pudlak Syndrome; or systemic sclerosis. I have never been diagnosed with any of these medical problems. I understand that if I am diagnosed with any of these medical problems, I should stop the entire treatment protocol immediately and notify my physician, so that my treatment plan can be re-evaluated.

I understand that part of my treatment program may involve taking growth hormone. Taking growth hormone raises the IGF-1 levels in the blood. In addition to the risks discussed above, I am aware that there are reports that indict=ate there may be an increased risk of prostate cancer associated with higher IGF-1 levels. In 1998, two published studies claimed to discover a higher incidence of prostate cancer among men who had higher IGF-1 levels in their blood when it was measured years before the onset if the cancer. However, other studies show no difference in IGF01 levels between normal healthy

men and those with prostate cancer when the IGF01 level was measured at the time of diagnosis and beyond. In a study of a large group of men taking both testosterone and growth hormone, completed by the National Institute on Aging (NIA) in 1999, the average PSA (prostate specific antigen) level actually declined over the 6 months of treatment. However, in my physician's opinion, the majority of data point toward safety. No one can prove or disprove a causal relationship between the use of growth hormone and prostate cancer.

I understand that careful surveillance and close monitoring of the prostate, as well as PSA levels are requirements of all Male patients to minimize any possible risk.

I understand I may request copies of all relevant studies known to my physician and that I may discuss them with my physician.

I understand any recent study points to a higher incidence of breast cancer in premenopausal (but not post-menopausal) women who had higher IGF-1 levels one to five years prior to the onset of breast cancer. However, studies like this, which show an association (two variables present simultaneously), do not demonstrate cause and effect.

I realize that it may be 20 years before we know if there is any true cause and effect between higher IGF-1 and increased risk for breast cancer in premenopausal women and increased risk for prostate cancer in men.

I also understand there are possible benefits associated with the procedure, which were listed in the literature I received from my physician and which I acknowledge I have read. I understand that no guarantee has been made to me regarding the outcome of this treatment. I also understand that the benefits derived from hormone therapy and drugs that alter hormone levels will reverse if the therapy is discontinued.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus.

I also understand that the therapy may include "off-label" use of FDA approved drugs such a Hydergine, Deprenyl, Anastrazole and Finasteride and others that may be recommended later. ("Off-Label" use means the use of DFA approved drugs for purposed other than those for which the FDA has approved them.) "Off-Label" prescribing is a legal and common practice by physicians in the United States.

I also understand that my physician may recommend the use of other drugs, which are only available outside the US and are not approved by the FDA. I understand that these products may only be available under the FDA's personal use importation policy. (The FDA allows for the importation of small amounts of drugs that are legal in other countries under the personal use importation policy if certain requirements are fulfilled.) I will use such drugs as directed for my condition and in accordance with the FDA's policy. I understand that the use of these medications is completely elective.

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for injecting and administering the hormones prescribed to me. I will conform and comply with the recommended dose and method of administration. I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels.

I authorize my physician to perform this treatment. I understand that they will be assisted by other health professionals, as necessary, and agree to their participation in my care as it related to anti-oxidant and hormone modulation therapy. I certify that I am under the regular care of another physician for all other medical conditions. I will consult my physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical consultation that I may need.

I assume full responsibility for any adverse effects that may result from the non-negligent administration of the proposal treatment. I waive any claim in law of equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of the procedure.

I hereby confirm that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and /or experimental because they are studies documenting the results.

The risks involved and the possibilities of complications not aimed at treating a disease, and there are no long-term have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

I further consent to the utilization of the results of my progress in any research study performed by my physicians.

I understand that my name will not be used and that every effort will be made to protect my privacy. I also understand that photographs taken of me by my physician will not be used without my written authorization.

I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension of termination.

I give my consent for this treatment and hereby affix my signature for authorization.

_____ _____

Name of Patient (please print) Date

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

If you are under the age of 18 years old, parental or legal guardian consent if required:

_____ _____

Parent or Legal Guardian Da

Credit Card Authorization Form:

1124 Floral Parkway
Wilmington, NC 28403
Tel. 910-520-1917 – Fax. 910-401-1464
Doccto@icloud.com – www.Metromedispa.com

I hereby authorize Metro Medi Spa PA, to charge my below card for services and products purchased. This includes phone, internet and in office purchases.

Type of Card: (Check one)

( ) Visa
( ) Master Card
( ) Discover
( ) American Express

Credit Card Information:

First: _____ Last: _____

Card Number: _____

Card Expiration: _____ Security Code: _____

Cardholder Information:

Cardholder Primary Phone #: _____ - _____ - _____

Signature of Cardholder: _____

Todays Date: _____