ReVita' Life
239 Hurffville-Cross Keys Road
Suite 250
Sewell, NJ 08080
P (856)-262-4750
F (856)-262-1635

ReVita' Life
2301 Evesham Road
Suite 106
Voorhees, NJ 08043
P (856)-262-4750
F (856)-262-1635

*Dear Sir,*

Welcome and thank you for inquiring about ReVita-Life bio-identical hormone replacement pellet therapy. We have included a new patient information packet which needs to be completed by you and sent to our office prior to your appointment. We thank you for taking the time to fill out this health questionnaire as it is ultimately used to ensure the best treatment and dose for your individual needs. Please also be sure to send along a copy of your insurance card both front and back. Please let us know what lab facility you are contracted with, i.e. Quest or Labcorp, so we can electronically send your prescription for bloodwork prior to your appointment. If you use a hospital lab, please let me know, as soon as possible so I can mail you a prescription. Please allow **at least** three weeks prior to your appointment to have your bloodwork drawn. You do not have to fast for this blood test.

**We will accept your insurance (if we are in network with your plan) for services related to your consultation only.** You will be responsible for all co-pays, co-insurances and the full cost of the sub-dermal bio-identical pellets. We accept Visa, MasterCard, Diners Club and American Express.

Your consultation will include a thorough review of your medical history, quality of life analysis, laboratory results and treatment recommendations. This visit will take approximately one hour. Additionally, should hormone replacement pellet therapy be indicated as a treatment option and desired by you following your consultation, you will be scheduled for your initial insertion 2 to 3 weeks later. You will be charged on exactly the dose of pellets you receive.

You will then be scheduled for a 6 week follow-up appointment after your initial pellet insertion. At that time, you will have a short consultation with your provider. That visit will be billed to your insurance carrier and you will be responsible for applicable co-pays. Occasionally, patients may require a booster pellet(s) at this visit. If so, there is an additional fee per pellet that you will be responsible for at the time of insertion.

Thereafter, pellet therapy is repeated every 4-6 months, pending your own personal needs and response to therapy and laboratory evaluation. Your re-insertion consultation will be billed to your insurance carrier and you will be responsible for applicable co-pays and cost of the pellet received.

**Please refrain from taking any baby aspirin, fish oil or anticoagulants for 5 days prior to pellet insertion.**

** Please note all correspondence and/or phone calls should be directed to our Sewell office. (856) 262-4750 and our fax # (856) 262-1635

We look forward to caring for you.

Valerie
Revitalife@axiawh.com
www.revitalifesouthjersey.com

3/2018

The following is a list of labs that we will be drawing for the initial consultation:

- DHEA SULFATE
- ESTRADIOL
- TESTOSTERONE, FREE AND TOTAL
- HEMOGLOBIN & HEMATOCRIT
- SEX HORMONE BINDING GLOBULIN
- PSA, % FREE AND TOTAL
- VITAMIN D, 25-OH, TOTAL
- TSH
- TRIIODOTHYRONINE, FREE
- THYROXINE, FREE

*Re-Vita' - Life*
*Sub-dermal Bio-identical Hormones*

Name (last):______________________________ (First) ___________________________(Middle)

Date of Birth: ____________________ Email Address:___________________________

Street Address: ____________________________________________________________________

City: ________________________________ State: __________ Zip Code: __________

Home Phone:______________Cell Phone: _______________Work Phone: ______________

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed

EMERGENCY CONTACT INFORMATION:

Name: __________________________________ Relationship: ___________________________

Phone#: ________________________________ Alternate Phone #:_____________________

PLEASE SHARE WITH US THE REASON FOR YOUR VISIT TODAY (please include specific symptoms and how you are currently managing those symptoms):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

HOW DID YOU HEAR ABOUT RE-VITA'-LIFE (sub-dermal bio-identical hormone pellets)?

________________________________________________________________________________

________________________________________________________________________________

Name: ______________________________ Date of Birth: _____________________

Please check the symptoms that may have caused you to seek Bio-identical Hormone Replacement:

| | |
|---|---|
| ◯ Fatigue | ◯ Poor erectile function |
| ◯ Mood Swings | ◯ Premature ejaculation |
| ◯ Unclear thinking | ◯ Disorders of the prostate |
| ◯ Memory loss | ◯ Decreased sex drive |
| ◯ Depression | ◯ Decreased energy level |
| ◯ Weight Gain | ◯ Poor exercise tolerance |
| ◯ Irritability | ◯ Muscle loss |
| ◯ Migraines | ◯ Heart diagnosis |

What have you done to manage these symptoms in the past?

_______________________________________________________________________

_______________________________________________________________________

Have you ever taken any herbal medications or supplements? YES / NO

Do you initiate intercourse? YES / NO

How often do you have intercourse? _____________________

Is intercourse satisfying for you? YES / NO

Do you achieve orgasm? YES / NO

Do you suffer from premature ejaculation? YES / NO

Is your sex drive the same as it was five years ago? YES / NO

Please describe:

_______________________________________________________________________

_______________________________________________________________________

List any other sexual problems you are experiencing:

_______________________________________________________________________

_______________________________________________________________________

Have you had any weight gain in the past 1-2 years? YES / NO If so, how much? ______

Have you had a weight loss of 10 or more pounds in less than a month? YES/ NO

Please describe:

_______________________________________________________________________

Name: ______________________________ Date of Birth: ______________

## MEDICAL HISTORY

1. Are you currently sexually active? YES / NO

2. Have you ever had a sexually transmitted disease? (STD) YES / NO
   Please describe:
   ______________________________________________
   ______________________________________________

3. Do you have a history of testicular cancer? YES / NO

   What treatment did you receive?
   ______________________________________________
   ______________________________________________

4. Have you ever been diagnosed with prostate problems? YES / NO

   ◯ Enlarged Prostate ◯ Prostatitis ◯ Prostate Cancer

   What treatment did you receive?______________________________
   ______________________________________________

5. Have you ever been told you have blood in your urine? YES / NO

   When? ____________

   How was it treated? ______________________________

6. Do you have a bladder or kidney problems? YES / NO

   Please describe: ______________________________

   What treatment, if any, did you receive? ____________________

7. Do you have erectile dysfunction? YES / NO

   Please describe the problem and any treatment received: ____________
   ______________________________________________
   ______________________________________________

Name: ______________________________ Date of Birth: _______________

# MEDICAL HISTORY

PAST MEDICAL HISTORY:

◯ Diabetes ◯ Blood clots/bleeding problems

◯ Heart Disease ◯ Psychiatric disorder

◯ Heart attack ◯ Cancer

◯ High blood pressure ◯ Prostate

◯ Thyroid disease ◯ Testicular

◯ Stroke ◯ Colon

◯ Liver Disease ◯ Breast

Have you seen your primary care doctor within the last year? YES / NO

If no, when were you last seen? ______________________

Have you had issues in the past with ◯ prostate ◯ hypertrophy ◯ cancer ◯ prostatitis?

Have you seen an urologist for any bladder issues such as infections, difficulty urinating?

YES / NO

PAST SURGICAL HISTORY

List all surgeries:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

FAMILY MEDICAL HISTORY

◯ Breast Cancer Relative(s):
◯ Colon Cancer Relative(s):
◯ Diabetes Relative(s):
◯ Heart Disease Relative(s):

Name: ______________________________________ Date of Birth: ________________

MEDICATIONS:

List any medications you are currently taking including over the counter herbs & supplements:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are you currently now or have ever used any Testosterone or Hormone Therapy? YES/NO

If so, please list the drugs and your reaction:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you have any DRUG ALLERGIES? YES / NO

If yes, please list the drugs and your reaction:

________________________________________________________________________
________________________________________________________________________

Do you smoke? Yes / No How long (years) _______ Pack per day: ______

Do you drink alcohol? Yes / No How much? ___________________

Do you use recreational drugs? Yes / No

If so, please describe: _______________________________________________

Name: ______________________________ Date of Birth: ______________

## *Re-Vita-Life*
## *Sub-dermal Bio-identical Hormone Replacement Pellets*

This is a scoring system to help us determine if your hormone levels are below optimum. It is designed to help the practitioner tailor your Bio-identical Hormones to meet your specific needs. Circle the score for each line then total the score at the bottom of each hormone.

### DHEA

| Signs & Symptoms | NEVER | | | ALWAYS | |
|---|---|---|---|---|---|
| 1. My hair is dry | 0 | 1 | 2 | 3 | 4 |
| 2. My skin & eyes are dry | 0 | 1 | 2 | 3 | 4 |
| 3. My muscles are flabby | 0 | 1 | 2 | 3 | 4 |
| 4. My belly is getting fat | 0 | 1 | 2 | 3 | 4 |
| 5. I don't have much hair under my arm | 0 | 1 | 2 | 3 | 4 |
| 6. I don't have much hair in the pubic area (0 = plenty hair / 4 = hairless) | 0 | 1 | 2 | 3 | 4 |
| 7. I don't have much fatty tissue in the pubic area (0 = padded / 4 = flat) | 0 | 1 | 2 | 3 | 4 |
| 8. My body doesn't have much of a special scent During sexual arousal | 0 | 1 | 2 | 3 | 4 |
| 9. I can't tolerate noise | 0 | 1 | 2 | 3 | 4 |
| 10. My libido is low | 0 | 1 | 2 | 3 | 4 |

**TOTAL** ________

### TESTOSTERONE

| Signs & Symptoms | NEVER | | | ALWAYS | |
|---|---|---|---|---|---|
| 1. My face has gotten slack and more wrinkled | 0 | 1 | 2 | 3 | 4 |
| 2. I've lost muscle tone | 0 | 1 | 2 | 3 | 4 |
| 3. My muscles are flabby | 0 | 1 | 2 | 3 | 4 |
| 4. I am constantly tired | 0 | 1 | 2 | 3 | 4 |
| 5. I feel like making love less often than I use to | 0 | 1 | 2 | 3 | 4 |
| 6. My breasts are getting fatty | 0 | 1 | 2 | 3 | 4 |
| 7. I feel less self-confident and more hesitant | 0 | 1 | 2 | 3 | 4 |
| 8. My sexual performance is poorer than it used to be | 0 | 1 | 2 | 3 | 4 |
| 9. I have hot flashes and sweats | 0 | 1 | 2 | 3 | 4 |
| 10. I tire easily with physical activity | 0 | 1 | 2 | 3 | 4 |

TOTAL ________

### THYROID

| Signs & Symptoms | NEVER | | | ALWAYS | |
|---|---|---|---|---|---|
| 1. I am sensitive to cold | 0 | 1 | 2 | 3 | 4 |
| 2. My hands & feet are always cold | 0 | 1 | 2 | 3 | 4 |
| 3. In the morning my face is puffy & my eyelids are swollen | 0 | 1 | 2 | 3 | 4 |
| 4. I put on weight easily | 0 | 1 | 2 | 3 | 4 |
| 5. I have dry skin | 0 | 1 | 2 | 3 | 4 |
| 6. I feel tired constantly | 0 | 1 | 2 | 3 | 4 |
| 7. I feel more tired at rest than when I am active | 0 | 1 | 2 | 3 | 4 |
| 8. I am constipated | 0 | 1 | 2 | 3 | 4 |
| 9. My joints are stiff in the morning | 0 | 1 | 2 | 3 | 4 |
| 10 I feel like I'm living in slow motion | 0 | 1 | 2 | 3 | 4 |

TOTAL _______

Name: ______________________________________ Date of Birth: _______________

Circle the answers to the ailments and discuss them with your physician.

**ENERGY**

| | | | |
|---|---|---|---|
| 1. | Do you have a hard time getting up in the morning | YES | NO |
| 2. | Do you always feel tired or tired in the afternoon | YES | NO |

**SEX**

| | | | |
|---|---|---|---|
| 1. | Do you lack sexual desire | YES | NO |
| 2. | Does your penis seem less sensitive | YES | NO |
| 3. | Are your erections not firm enough | YES | NO |
| 4. | Have you lost your attraction toward your partner | YES | NO |

**SLEEP**

| | | | |
|---|---|---|---|
| 1. | Do you sleep poorly | YES | NO |
| 2. | Do you rarely dream | YES | NO |

**MEMORY**

| | | | |
|---|---|---|---|
| 1. | Do you suffer from short or long term memory loss | YES | NO |
| 2. | Do you have trouble concentrating | YES | NO |

**SKIN & HAIR**

| | | | |
|---|---|---|---|
| 1. | Wrinkles on your face along the nose, smile line, Forehead creases | YES | NO |
| 2. | Do you have little wrinkles around the eyes and crows feet | YES | NO |
| 3. | Do you have age spots | YES | NO |
| 4. | Do you have dry, thin skin | YES | NO |
| 5. | Are you losing your hair or is it turning gray | YES | NO |

**WEIGHT CONTROL**

| | | | |
|---|---|---|---|
| 1. | Is your abdomen too plump/distended | YES | NO |
| 2. | Are your breasts too large | YES | NO |
| 3. | Are your buttocks & thighs to well padded | YES | NO |
| 4. | Are you pear shaped | YES | NO |

**STRESS & MOOD**

| | | | |
|---|---|---|---|
| 1. | Do you suffer from constant fatigue | YES | NO |
| 2. | Do you have high blood pressure | YES | NO |
| 3. | Are you anxious, nervous, irritable | YES | NO |
| 4. | Do small things set you off | YES | NO |
| 5. | Are you depressed | YES | NO |

**JOINTS & BONES**

| | | | |
|---|---|---|---|
| 1. | Do you have arthritis | YES | NO |
| 2. | Do you have osteoarthritis in the hip | YES | NO |
| 3. | Do you have fibromyalgia (sharp shoulder pain) | YES | NO |
| 4. | Have you lost muscle mass, tone & strength | YES | NO |
| 5. | Do you have bone loss of the spine, hips hands, wrist and feet | YES | NO |

To our Medicare and Horizon Patients,

Please be advised that Medicare and some Horizon insurances may or may NOT cover some of the blood work that we require. These tests may include the Vitamin D level and Thyroid panel. When you go to your lab facility they will ask you to sign an "ABN" (Advanced Beneficiary Notice of Non-Coverage) form. This form allows you to choose whether or not to have these tests drawn.

It is the patient's responsibility to check with their insurance company so you are aware of your coverage.

In order for the provider to give you an accurate diagnosis and the best possible care and treatment, we feel it is important to have the thyroid panel and vitamin D level drawn.

______________________________ __________________

Signature Date