TRT / Men's Health Patient Intake

TRT & MEN'S HEALTH PRACTICE PACK

Patient / DOB _____

Height / weight _____

Primary symptoms / goals _____

Current medications / supplements _____

Allergies _____

Prior testosterone / hormone therapy _____

- ■ Cardiovascular disease
- ■ Hypertension
- ■ Sleep apnea
- ■ Prostate condition
- ■ Elevated hematocrit history
- ■ Clotting history
- ■ Infertility concerns
- ■ Breast/chest symptoms
- ■ Liver/kidney disease
- ■ Mood/behavioral health concern
- ■ Current fertility plans
- ■ Other clinician-review concern

Relevant labs / dates _____

Assessment / eligibility considerations _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Testosterone Therapy Informed Consent

TRT & MEN'S HEALTH PRACTICE PACK

I consent to testosterone therapy when prescribed by my clinician. I understand treatment requires individualized assessment and monitoring and that symptom response and laboratory response vary.

- ■ Acne / oily skin
- ■ Fluid retention
- ■ Changes in mood or libido
- ■ Testicular volume changes
- ■ Worsening sleep apnea
- ■ Cardiovascular risk discussion when clinically relevant
- ■ Hair changes
- ■ Breast/chest tenderness
- ■ Reduced sperm production / fertility impact
- ■ Elevated hematocrit / erythrocytosis
- ■ Prostate/urinary considerations
- ■ Medication-specific adverse effects

Medication / route _____

Indication _____

Alternatives / special risks discussed _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Fertility Impact Acknowledgment

TRT & MEN'S HEALTH PRACTICE PACK

I understand exogenous testosterone can suppress the body's reproductive hormone signaling and may reduce sperm production and fertility. Recovery after discontinuation is variable and may take time.

Current fertility goals _____

Fertility preservation/referral discussed _____

Alternative strategy discussed if applicable _____

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Clinician/Reviewer: _____ **Date:** _____

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TRT Laboratory Monitoring Agreement

TRT & MEN'S HEALTH PRACTICE PACK

- ■ Baseline laboratory evaluation reviewed
- ■ CBC / hematocrit monitoring planned
- ■ Metabolic/lipid monitoring as indicated
- ■ Dose changes based on clinical/lab findings
- ■ Follow-up testosterone level planned
- ■ PSA/prostate assessment when clinically indicated
- ■ Adverse symptoms reviewed at follow-up

Monitoring schedule _____

Target follow-up date _____

Additional labs / rationale _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Testosterone Injection Training Acknowledgment

TRT & MEN'S HEALTH PRACTICE PACK

- ■ Medication/concentration verified
- ■ Syringe/needle selection reviewed
- ■ Aseptic technique reviewed
- ■ Storage instructions reviewed
- ■ Patient return-demonstration completed
- ■ Prescribed dose reviewed
- ■ Injection route/site demonstrated
- ■ Sharps disposal reviewed
- ■ Missed-dose instructions reviewed

Medication / concentration _____

Dose / frequency _____

Training notes _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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TRT Follow-Up Questionnaire

TRT & MEN'S HEALTH PRACTICE PACK

Current medication / dose _____

Last dose date _____

Energy / stamina _____

Libido / sexual function _____

Mood / cognition _____

Sleep _____

Exercise / body composition changes _____

- ■ Acne
- ■ Shortness of breath
- ■ Urinary changes
- ■ Mood changes
- ■ Other adverse effects
- ■ Swelling
- ■ Headache
- ■ Breast/chest symptoms
- ■ Injection-site issue

Patient questions / goals _____

Clinician plan _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Controlled Medication Safety Agreement - Men's Health

TRT & MEN'S HEALTH PRACTICE PACK

- ■ I will use medication only as prescribed.
- ■ I will disclose controlled medications from other clinicians.
- ■ I will store medication securely.
- ■ I will report significant adverse effects.
- ■ I will not share, sell, or divert medication.
- ■ I will complete clinically appropriate monitoring.
- ■ I understand early replacement is not guaranteed.
- ■ I understand treatment may change when risks outweigh benefits.

Designated pharmacy _____

Monitoring expectations _____

Additional practice-specific terms _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Men's Health Treatment Goals & Follow-Up Plan

TRT & MEN'S HEALTH PRACTICE PACK

I understand treatment should be based on symptoms, examination/history, appropriate diagnostic evaluation, shared decision-making, and ongoing monitoring rather than a guaranteed laboratory target or cosmetic outcome.

Goal 1 _____

Goal 2 _____

Goal 3 _____

Follow-up interval / monitoring plan _____

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Clinician/Reviewer: _____ **Date:** _____

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