



ReVita' Life  
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Suite 2C  
Sewell, NJ 08080  
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F (856)-318-1675

ReVita' Life  
2301 E. Evesham Road  
Suite 106  
Voorhees, NJ 08043  
P (856)-262-4750  
F (856)-318-1675

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) 318-1675

We look forward to caring for you.

Valerie  
[Revitalife@axiawh.com](mailto:Revitalife@axiawh.com)

8/2021

**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):

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

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please check the symptoms and their severity that brought you to seek our care:

SYMPTOM	SEVERITY			
	Never	Mild	Moderate	Severe
Joint Pain/Muscle Aches				
Sleep Problems				
Feeling Tired, Unmotivated, Exhausted				
Irritability, Aggressive, Easily Upset, Moody				
Nervousness, Anxiety				
Depressed Mood/Feeling Down or Sad				
Lack of Focus/Concentration				
Forgetfulness				
Decreased Muscle Strength				
Weight Gain/Belly Fat				
Breast Development				
Shrinking Testicles				
Migraines				
Decreased Desire for Sex/Low Libido				
Decreased Morning Erection				
Decreased Ability to Perform Sexually				
Penis Less Firm				
Infrequent or Absent Ejaculation				
No Results from ED Meds				
Cardiac Issues				
Diabetes				
Prostate Issues				

Please list any other symptoms that might concern you:

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

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Have you ever taken or are currently taking 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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Please describe:

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List any other sexual problems you are experiencing:

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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:

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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:

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

What treatment did you receive?

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

☐ Enlarged Prostate    ☐ Prostatitis    ☐ Prostate Cancer

What treatment did you receive? \_\_\_\_\_

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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: \_\_\_\_\_

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **MEDICAL HISTORY**

#### **PAST MEDICAL HISTORY:**

- |                                           |                                                        |
|-------------------------------------------|--------------------------------------------------------|
| <input type="radio"/> Diabetes            | <input type="radio"/> Blood clots/in extremities/lungs |
| <input type="radio"/> Heart Disease       | <input type="radio"/> Psychiatric disorder             |
| <input type="radio"/> Heart attack        | <input type="radio"/> Cancer of the following:         |
| <input type="radio"/> High blood pressure | <input type="radio"/> Prostate                         |
| <input type="radio"/> Thyroid disease     | <input type="radio"/> Testicular                       |
| <input type="radio"/> Stroke              | <input type="radio"/> Colon                            |
| <input type="radio"/> Liver Disease       | <input type="radio"/> 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 a urologist for any bladder issues such as infections, difficulty urinating?

YES / NO

#### **PAST SURGICAL HISTORY**

List all surgeries:

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#### **FAMILY MEDICAL HISTORY**

- |                                     |              |
|-------------------------------------|--------------|
| <input type="radio"/> Breast Cancer | Relative(s): |
| <input type="radio"/> Colon Cancer  | Relative(s): |
| <input type="radio"/> Diabetes      | Relative(s): |
| <input type="radio"/> Heart Disease | Relative(s): |

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

MEDICATIONS:

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

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

If so, please list the drugs and your reaction:

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Do you have any DRUG ALLERGIES? YES / NO

If yes, please list the drugs and your reaction:

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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: \_\_\_\_\_

**Initial Hormone Levels for Males:**

TSH

T3 Free

T4 Free

Estradiol

Testosterone – Free and Total

PSA

SHBG

Hemoglobin & Hematocrit

DHEA

Vitamin D3 OH