

## AIRMEN TESTOSTERONE STATUS REPORT

**\*Are you currently getting treated with ONLY Topical Testosterone? If so, disregard this form. If not, please complete this form.**

**\*In addition to this form, you will need to bring a current detailed clinical progress note from the treating physician that finds: This condition is stable on the current regimen & no changes are recommended. You will also need to bring CBC labs performed within the last 90 days to your visit.**

**Airman's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**1) Diagnosis:** \_\_\_\_\_

**2) Treatment (Medication & Dosage):** \_\_\_\_\_

**3) Adverse side effects experienced by patient:**

\_\_\_\_\_  
\_\_\_\_\_

**4) Select which medications are used for this condition (NOTE: Enclomiphene Citrate is NOT acceptable). Please select one or more of the following:**

- ☐ Anastrozole
- ☐ Human Chorionic Gonadotropin (HCG)
- ☐ Testopel
- ☐ Testosterone (Oral or Injectable)
- ☐ Clomiphene Citrate (Requires a 14 day initial ground trial & AME must confirm no visual side effects present)

**5) Circle "Yes" or "No" for the following questions:**

- |                                                                    |     |    |
|--------------------------------------------------------------------|-----|----|
| 1) Does the Individual require treatment with Phlebotomy?          | YES | NO |
| 2) Does the individual have any history of Cardiovascular Disease? | YES | NO |
| 3) Does the individual have any history of Thromboembolic Events?  | YES | NO |
| 4) Does the individual have a history of Prostate Cancer?          | YES | NO |

**Recommendations:**

\_\_\_\_\_  
\_\_\_\_\_

**Physicians Name (Please Print):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_