

CME CERTIFICATE REGISTRATION AND EVALUATION

To enable us to maintain the highest scientific and educational standards when planning future activities, we would appreciate your evaluation of this activity and its content. Please circle the appropriate rating numbers and add your comments for the Evaluation. In the box below, please circle the best answers to the posttest questions, which are provided on the back of this page. Fax the completed form to 877-403-5765, or mail it to TestosteroneUpdate, c/o CogniMed Inc., 70 South Orange Avenue, Suite 200, Livingston, NJ 07039.

Your certificate for continuing education credit (if applicable) will be issued from the following information.

Name _____ Title _____
Last First MI

What is your professional degree? MD DO RN LPN LVN NP Lic. # _____ PhD MA MSW Other _____

Specialty Endocrinology Family medicine Internal medicine Primary care Psychology Psychiatry Urology

Other (please specify) _____ Years in practice _____

Affiliation _____

Practice type (please check all that apply to your practice) Hospital-based University-based Private practice Clinic Home care

Long-term care Other (please specify) _____
Street City State ZIP

Address Business Personal _____

Daytime phone _____ Ext. _____ Fax _____ Date of birth ____/____/____ (used for record-keeping purposes only)

E-mail _____

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EVALUATION

As a result of this activity, I am better able to:	Agree					Disagree				
Recognize the broad physiologic effects of low testosterone levels on men's health	5	4	3	2	1	5	4	3	2	1
Describe recent data that are reversing traditional paradigms about the relationship of testosterone with cardiovascular disease and prostate health	5	4	3	2	1	5	4	3	2	1
Identify and appropriately screen patients who may be hypogonadal	5	4	3	2	1	5	4	3	2	1
Diagnose and determine the etiology of hypogonadism and appropriately treat men who are found to be hypogonadal	5	4	3	2	1	5	4	3	2	1
Educate and counsel patients who are hypogonadal about the benefits and risks of the various testosterone treatment options	5	4	3	2	1	5	4	3	2	1
Follow-up and monitor therapy to enhance patient satisfaction, improve adherence, and increase the likelihood of successful testosterone treatment	5	4	3	2	1	5	4	3	2	1

The Activity:	Agree					Disagree				
Met my expectations	5	4	3	2	1	5	4	3	2	1
Was relevant to my clinical practice	5	4	3	2	1	5	4	3	2	1
Was presented without commercial bias	5	4	3	2	1	5	4	3	2	1

After participating in this activity, I will change my clinical practice by: _____

Additional comments: _____

Posttest Answer Box

1. a b c d	3. a b c d	5. a b c d	7. a b	9. a b c d
2. a b c d e	4. a b c d e	6. a b c d e	8. a b c d	10. a b

I hereby certify that I have spent _____ hour(s) in this educational activity.

Signature _____ Date _____

Thank you.

POSTTEST

In the CME Certificate Registration and Evaluation Posttest Answer Box (provided on the front of this page), please circle the letter that best answers each question. Fax the completed form to 877-403-5765, or mail it to TestosteroneUpdate, c/o CogniMed Inc., 70 South Orange Avenue, Suite 200, Livingston, NJ 07039.

This activity was originally released December 15, 2008, and is eligible for credit through December 15, 2009.

1. Hypogonadism should be diagnosed for:
 - a. Any male patient with testosterone levels <300 ng/dL
 - b. Men with low levels of testosterone and signs and symptoms of hypogonadism
 - c. All men with testosterone levels between 200 and 320 ng/dL
 - d. None of the above
2. For which of the following patients is screening for testosterone levels recommended?
 - a. Male patients being treated with glucocorticoids, ketoconazole, or opioids
 - b. Male patients with human immunodeficiency virus-associated weight loss
 - c. Male patients with type 2 diabetes
 - d. All of the above
 - e. None of the above
3. Differential diagnosis of primary (hypogonadotropic) versus secondary (hypergonadotropic) hypogonadism is made by:
 - a. Measuring LH and FSH levels
 - b. Assessing SHBG levels
 - c. Obtaining a karyotype
 - d. Performing seminal fluid analysis
4. With which of the following medical conditions has hypogonadism been associated?
 - a. Metabolic syndrome
 - b. Aortic atherosclerosis
 - c. Premature death
 - d. All of the above
 - e. None of the above
5. Which testosterone formulation is most likely to cause erythrocytosis, fluctuating testosterone levels, and hypogonadal symptoms?
 - a. Injectable testosterone cypionate or testosterone enanthate
 - b. Topical gel
 - c. Transdermal patch
 - d. Buccal tablet
6. What is the major potential problem associated with topical gels?
 - a. Application-site skin reactions
 - b. Extreme testosterone peaks and nadirs and mood fluctuations
 - c. Skin-to-skin transference to others
 - d. All of the above
 - e. None of the above
7. In contrast to the traditional paradigm, it is men with below-normal testosterone levels who are at greater risk for prostate cancer.
 - a. True
 - b. False
8. Which of the following statements is true?
 - a. Serum PSA levels increase during the first 3 months of testosterone therapy and then plateau
 - b. The combination of low serum testosterone level and PSA level >2.0 ng/mL has been associated with the highest risk of prostate cancer
 - c. Both statements are true
 - d. Neither statement is true
9. When should testosterone levels be monitored for patients using the transdermal patch?
 - a. Only midway between injections, which will determine average concentrations between peaks and nadirs
 - b. At any time after 1 week of therapy, when concentrations reach steady state
 - c. Between 3 and 12 hours after application
 - d. Immediately after application of a fresh patch
10. Patients need thorough education about the various testosterone formulations to make an optimal choice, because switching between different formulations is not recommended.
 - a. True
 - b. False