

# Medical History Form



\* Required Fields

## SECTION 1: Personal information

\* First Name:

Middle Name:

\* Last Name:

\* Email Address:

\* Driver License:

### ADDRESS

\* Address 1:

Address 2:

\* City:

\* State:

\* Zip:

\* Country:

### PHONE NUMBERS

Home:

Best time to call:

Work:

Best time to call:

Cell:

Best time to call:

### OTHER

\* Occupation:

Have you already contacted Hormone Therapeutics?  
Please provide the name of your Clinical Adviser:

## SECTION 2: Medical history

### GENERAL

\* Date of birth:    \* Weight:

\* Gender:  Male  Female \* Height:

### PRIMARY PHYSICIAN INFORMATION

Physicians Name:  Phone:

Date of last physical exam with above physician:

Last Colonoscopy Date:  Last Prostate Exam:

Vasectomy:  Yes  No

## FAMILY HISTORY

Does an **immediate family member** currently have or ever had any of the following?

If yes, please check below and explain in the provided field:

\* Cardiovascular disease:  Yes  No

\* Diabetes, thyroid or other Endocrine Disorder:  Yes  No

\* Hypertension:  Yes  No

\* Lipid Disorder:  Yes  No

\* Prostate cancer:  Yes  No

\* Other forms of cancer:  Yes  No

\* Other illnesses:  Yes  No

Explain family health history:

## LIFESTYLE INFORMATION

\* Do you smoke?  Yes  No

If Yes, how much do you smoke per day?

\* Do you drink alcohol?  Yes  No

If Yes, how much do you drink per week?

\* Do you take over the counter supplements?  Yes  No

If Yes, list Name and Quantity per day/week.

\* Do you exercise regularly?  Yes  No

If Yes, please describe.

Are you in any branch of military service as either active duty or reservist?  Yes  No

Do you have plans to enter any branch of military service as either active duty or reservist?  Yes  No

## DIAGNOSED HISTORY OF DISEASE

Do you currently have or ever had any of the following?

If yes, please check below and explain in the provided field:

\* Any known deficiency including minerals and electrolytes:  Yes  No

\* Use of medications (if yes, list medications below):  Yes  No

\* Blood disorders:  Yes  No

\* Immune disorders:  Yes  No

\* Cancer:  Yes  No

\* Chemical Dependency:  Yes  No

\* Carpal Tunnel syndrome:  Yes  No

\* Lung disorder:  Yes  No

\* Orthopedic or muscle disorder including fracture or joint disorders:  Yes  No

\* Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack:  Yes  No

\* Allergies to Medications:  Yes  No

\* Upper respiratory:  Yes  No

\* Edema / excess fluid retention:  Yes  No

\* Poor wound healing:  Yes  No

\* Emotional disorders / depression:  Yes  No

\* Renal disease:  Yes  No

\* Genital - Urinary disorder:  Yes  No

\* Hyperlipidemia:  Yes  No

\* Hypertension:  Yes  No

\* Neurological disorders:  Yes  No

\* Thyroid, Diabetes or other endocrine disorder including insulin resistance:  Yes  No

\* Arthritis:  Yes  No

\* Bursitis:  Yes  No

\* Rheumatism:  Yes  No

\* Sports Injury(s):  Yes  No

\* Other illnesses:  Yes  No

Explain the history of any above checked diseases:

\* List all the medications you are taking.

Please be specific (Name, dosage, etc.) or specify "none":

## DIAGNOSED HISTORY OF DISEASE

\* Prior history of Steroids or hormones?

Yes  No

If yes, please select:

### Male

Test:  Yes  No

Deca:  Yes  No

Winstrol:  Yes  No

hGH:  Yes  No

Thyroid:  Yes  No

Other:  Yes  No

Type/Dose/Frequency:

Type/Dose/Frequency:

Prior Medical Records / Labs?

Yes  No

Any side affects?

Used estrogen-blocker?

Yes  No

## QUESTIONS FOR TREATMENT

**Prospective Patients:** Please check the symptoms you hope to improve through hormone replacement therapy (HRT)

**Existing Patients:** Please check the symptoms you have improved and hope to continue to improve through HRT.

**HORMONE THERAPEUTICS AND ITS PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT. We do not treat bodybuilders or professional athletes. We do not treat those who are currently in any branch of military service (active duty or reservist) or those who anticipate entering the military while taking any therapeutic program which may be prescribed for you. You must have a verified deficiency and medical need to qualify for treatment by our physicians.**

Do you currently have or ever had any of the following symptoms?

If Yes, please check and explain below:

\* Increased lack of drive:  Yes  No

\* Increasing fat deposits around the abdomen and/or thighs:  Yes  No

\* Increasing mood swings:  Yes  No

\* Increasing sagging muscles or breasts:  Yes  No

\* Increasing wrinkles:  Yes  No

\* Increasingly stressed:  Yes  No

\* Currently Pregnant:  Yes  No

\* Depression:  Yes  No

\* Difficulty sleeping:  Yes  No

\* Headaches / Migraines:  Yes  No

\* Hot flashes:  Yes  No

\* Loss of concentration, sociability, activity:  Yes  No

\* Loss of interest in sex:  Yes  No

- \* Decreased desire and ability to exercise:  Yes  No
- \* Decreased energy or endurance:  Yes  No
- \* Decreased sense of well-being:  Yes  No
- \* Decreasing memory:  Yes  No
- \* Decreasing muscle strength:  Yes  No
- \* Decreasing size of testicles:  Yes  No
- \* Progressive osteoporosis, decreasing bone mass or stooped posture:  Yes  No
- \* Cold or heat intolerance:  Yes  No

- \* Muscle loss:  Yes  No
- \* Sagging, loose or thin skin:  Yes  No
- \* Sore Muscles, joint pain(s) or swelling:  Yes  No
- \* Thinning or loss of hair:  Yes  No
- \* Urogenital atrophy:  Yes  No
- \* Weight loss - Unexplained:  Yes  No
- \* Other:  Yes  No

Please use this space to explain any additional information:

## SECTION 3: Signature

### **Patient Authorization and Agreement**

The undersigned Patient (“Patient”) authorizes and instructs Hormone Therapeutics (“Hormone Therapeutics”) to provide the Patient with medical management, administrative and referral services. Patient acknowledges and agrees to the following terms and conditions contained in this Patient Authorization Agreement (“Agreement”). Patient submits with this Agreement an accurately completed Medical History Form (“MHF”). Patient agrees to respond truthfully, accurately and completely on the MHF and acknowledges that failure to provide truthful, accurate and complete information on the MHF or to the physicians referred by Hormone Therapeutics (“Physicians”) could result in inappropriate treatment. Patient authorizes Hormone Therapeutics to receive copies of reports from medical laboratories, diagnostic testing services, Physicians and dispensing pharmacies relating to his/her treatment. In addition, Patient authorizes and instructs Hormone Therapeutics, Physicians and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the information contained on the MHF, laboratory diagnostic tests, and other information submitted to Hormone Therapeutics under this Agreement. Patient agrees to present photo identification upon receiving any blood testing pursuant to a Hormone Therapeutics or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by Hormone Therapeutics, and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or any other insurance.

Patient specifically swears and acknowledges that he or she is not a professional or amateur athlete or bodybuilder. Patient specifically swears and acknowledges that he or she is not seeking treatment or prescription medication by Hormone Therapeutics and/or Physician for the purpose of athletic or performance or cosmetic enhancement. It is outside the scope of Hormone Therapeutics and the Physician to provide these services or prescriptions under those circumstances. Hormone Therapeutics and the Physician only provide treatment and prescription medication to patients who have a deficiency and medical need as established by

laboratory blood tests, physical examination, this MHF and in the sole determination of the Physician.

Patient acknowledges that Hormone Therapeutics's employees and clinical advisers are not licensed physicians and that Physicians obtained on my behalf by Hormone Therapeutics are independent contractors, which will be compensated by Patient with funds provided to Hormone Therapeutics. I further understand and agree that Hormone Therapeutics and Physicians are rendering the medical care, services and treatment, and that Hormone Therapeutics is instructed and authorized to arrange for the prescribed pharmaceuticals to be dispensed and sent to me by any pharmacy in my country of residence.

Patient covenants and agrees to comply with the method of instructions, treatment and dosage schedules prescribed by Physician, to immediately cease any medical treatment prescribed by Physician in the event of any adverse reaction or side effect arising from prescribed treatment and to immediately provide Hormone Therapeutics and Physician with written notice of any such adverse reaction or side effect. I further acknowledge and agree that Hormone Therapeutics is not liable for any negligent act or omission of the Physician.

Patient acknowledges that diagnosis and treatment may involve risk of injury, and that Hormone Therapeutics and Physician have made no guarantees or warranties with respect to the above-described diagnostic testing, analysis of test results, examination of medical history or hormone treatment. Patient acknowledges that the hormone blood level objective sought as a result of Patient's hormone replacement therapy, as prescribed by Physician, may be the highest level of standard reference range for Patient's age and sex, or, in some cases, above such range, to the level of a younger person, and that such range is experimental and may not render any benefits, but may result in unknown, adverse results.

Patient is aware of the nature, risk and possible alternative methods of treatment, possible consequences, and possible complications involved in such hormone replacement treatment. Patient acknowledges that recombinant human growth hormone replacement therapy involves the use of a medical drug approved for one purpose and being utilized for a new and different purpose in an effort to obtain a desired objective of medical treatment. Nonetheless, Patient consents to such care and treatment, and executes this Agreement with a complete, informed understanding of such hormone replacement therapy for the purpose of authorizing Physician to administer such treatment to relieve body ailments and deficiencies. Patient further acknowledges that the methods of medical treatment offered by Hormone Therapeutics and Physician are not accompanied by claims, guarantees, promises or warranties. In compliance with federal and state laws, there will be no refund given for any medication.

Patient is freely seeking medical consultation via the internet and acknowledges and consents to Physician reviewing Patient's medical history without the opportunity to conduct an in-person physical examination. Patient has contacted Hormone Therapeutics for a specific prescription medication to treat an already-identified medical condition. Patient acknowledges that Physician may not be licensed to practice medicine in Patient's state or country of residence. Further, Patient agrees that Physician's consultations, diagnosis, and treatments will be deemed to have occurred in Florida.

Patient represents that he or she is under the care of a primary care physician and the Physician, and he or she will not rely or substitute the advice of Physician should it conflict with the advice given by Patient's primary care physician. Before qualifying for any treatment or any medication prescribed by Physician, Patient agrees to have a comprehensive physical examination and to submit same to become a part of patient's records to be maintained by Hormone Therapeutics. Patient agrees to notify his or her primary care physician and advise such physician that Patient is undergoing hormone replacement therapy.

This Agreement shall be governed, construed and enforced in accordance with the laws of the State of Florida, applicable to agreements made and to be performed entirely within such State, without regard to principles of conflict of laws. Any disputes arising out of, in connection with or with respect to this Agreement, shall be adjudicated in a court of competent jurisdiction sitting in the Broward County, Florida and nowhere else. Patient hereby irrevocably submits to the jurisdiction of such court for the purposes of any suit, civil action or other proceeding arising out of, in connection with or with respect to this Agreement. In the event of any litigation

arising out of this Agreement, the prevailing party shall be entitled to recover all expenses and costs incurred, including reasonable attorneys' fees and legal assistants' fees.

This Agreement contains the entire understanding of the parties and supersedes and merges all prior and contemporaneous agreements and discussions between the parties. Any and all representations or agreements by any agent or representative of either party not contained in this Agreement shall be null, void and of no effect. If any provision of the Agreement or the application thereof to any person or circumstances is held invalid or unenforceable in any jurisdiction, the remainder hereof, and the application of such provision to such person or circumstances in any other jurisdiction, shall not be affected thereby, and to this end the provisions of this Agreement shall be severable.

Patient covenants and agrees to indemnify, defend, protect and hold harmless Hormone Therapeutics and Physician and their respective officers, directors, employees, stockholders, assigns, successors and affiliates ("Indemnified Parties") from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceedings, investigations, demand, judgments, settlement payments, deficiencies, penalties, fines, interest and costs and expenses suffered, sustained, incurred or paid by the Indemnified Parties in connection with, resulting from or arising out of, directly or indirectly, Hormone Therapeutics and/or Physician's rendering medical care, services, advice and/or treatment.

Patient's failure to disclose all relevant information regarding Patient's medical and physical condition, may result in acts or omissions by Hormone Therapeutics or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Hormone Therapeutics or Physician. Patient is aware of potential side effects associated with the above-described treatment, accepts all risks involved in taking medication and will not seek indemnification or damages from the Indemnified Parties herein.

Liability Waiver and Hold Harmless: I voluntarily choose to undergo hormone replacement therapy. All potential risks and side effects have been fully explained to me. I acknowledge and understand those risks. I have assessed the risk on a personal basis, and my personal belief is the benefits of hormone therapy out weighs the risks (including the possibility of raised prostate levels which some physicians think could possibly lead to prostate cancer). I hereby release and agree to hold harmless Hormone Therapeutics, the entire Staff at Hormone Therapeutics and the prescribing Physician associated with my hormone replacement therapy. I have had adequate time to consider all options and research hormone replacement therapies. This agreement shall serve as release and hold harmless and is binding on behalf of myself, my heirs, assignees, designees, and personal representatives.

\* I understand that the medications I have purchased are prescribed for me based on diagnosis derived from my submitted medical history, blood and lab report, and physical examination. They are to be based exclusively for treatment of this diagnosis.

\* I will immediately report any adverse side effects related to the use of my medication to Hormone Therapeutics and discontinue use until advised to resume usage by Hormone Therapeutics.

\* I will safeguard my medications from loss or theft.

\* I understand that Hormone Therapeutics does not cooperate with any insurance companies. If any part of my prescription from Hormone Therapeutics's doctors is to be picked up at a local pharmacy, I agree to pay cash for that medication. I will not request that it be processed through my insurance.

\* I will not sell, share or trade my medications for money, goods or services.

\* I agree that I will use my medications at the prescribed rate and dosage, and I will keep the medications in its respective labeled container.

\* I will not attempt to obtain “scheduled” hormone replacement therapy medications illegally or from any other health care practitioner without disclosing my current medication usage. I understand that it is illegal to do so.

\* I attest I am not seeking medical treatment for body enhancement, body building or performance enhancement or cosmetic enhancement of any kind.

\* I attest I am not currently in any branch of the military service as either active duty or reserve capacity. I will not enter military service while I am undergoing this course of therapy, if one is prescribed for me.

\* I am seeking this treatment for legitimate medical purposes.

\* I have read the text above, and I agree to the terms and conditions disclosed herein.

\* Print Name:

\* Signature: