Medical History Form

Section 1. Personal Information

FIRST NAME: _____

LAST NAME: _____

EMAIL ADDRESS: _____

Address and Phone Numbers

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip: _____

Country: _____

PHONE:

Home: _____

Work: _____

Mobile: _____

Fax: _____

Occupation: _____

Section 2. Confidential Medical History

Medical History Information

Date of Birth*: _____

Gender* (circle one)

Male Female

Weight: _____

Height: _____

Primary Physician Information

Physician's Name: _____

Physician's Phone: _____

Date of your last physical examination with your physician?: _____

Lifestyle Information

(Please Circle)

Do you smoke?

Yes No

Do you drink alcohol?

Yes No

Are you taking over the counter supplements?

Yes No

Do you exercise regularly?

Yes No

Diagnosed History of Disease: Do YOU currently have or have ever had any of the following? If yes, please explain in the box below:

Circle Yes or No for each:

Heart Failure / Heart Attack
Yes No

Liver Disease
Yes No

Renal Disease
Yes No

Asthma/COPD
Yes No

Orthopedic or muscle disorder including fracture or joint disorders
Yes No

Allergies to Medications
Yes No

Fibromialgia
Yes No

Anxiety
Yes No

Erectile Dysfunction
Yes No

Back Problems/Injury
Yes No

Diabetes
Yes No

Hypertension
Yes No

Cancer
Yes No

Cholesterol Problems
Yes No

Anemia
Yes No

Thyroid Problems
Yes No

Please list surgeries, hospitalizations, and diseases here:

List all of the medications you are taking. Please be specific (name, dosage, etc.) or specify “none”:

List allergies to any medication:

List all vitamins and supplements you are currently taking:

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

*AGELESS MEDICINE OF THE PALM BEACHES AND ITS PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT

Questions for Treatment: Do you currently have or ever had any of the following symptoms?

Circle Yes or No for each:

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

Cold or heat intelorance
Yes No

Increasingly Stressed
Yes No

Loss of interest in sex/low Libido
Yes No

Decreased muscle strength
Yes No

Loss of concentration, sociability, activity
Yes No

Depression
Yes No

Difficulty sleeping
Yes No

Hot flashes
Yes No

Increasing fat deposits about abdomen and/or thighs
Yes No

Muscle loss
Yes No

Thinning or loss of hair
Yes No

Headaches / Migraines
Yes No

Weight loss - Unexplained
Yes No

Other
Yes No

Use the space below to explain any “other” symptoms from which you may be suffering and write any additional information:

Family History:

Does an IMMEDIATE FAMILY MEMBER currently have or ever had any of the following? Please circle and explain below:

Heart Disease
Yes No

Diabetes
Yes No

Thyroid Problems
Yes No

High Blood Pressure
Yes No

Cholesterol Problems
Yes No

Cancer
Yes No

Osteoporosis
Yes No

Anemia
Yes No

Please use this space to explain any “Yes” answer and write any additional information regarding any of the above medical condition(s) that an IMMEDIATE FAMILY MEMBER may have, or have had:

SIGNATURE PAGE

PATIENT'S AGREEMENT AND RELEASE

THIS AGREEMENT is made and executed on the* between Ageless Medicine of the Palm Beaches. (Hereinafter referred to as “AMPB”) and (hereinafter referred to as “Patient”).

IN CONSIDERATION of the AMPB, providing Patient with medical management, administrative and referral services, Patient acknowledges, understands and agrees to the following terms and conditions as set forth herein.

MEDICAL HISTORY FORM: Patient will submit an accurately completed Medical History Form. Patient agrees to fill in the Medical History Form truthfully, accurately and completely and acknowledges, understands and agrees that failure to provide truthful, accurate and complete information on this form to AMPB or to the physician(s) referred to by AMPB (hereinafter “physicians” or “its physicians”) will result in inappropriate treatment and constitute a material breach of this Agreement.

AUTHORIZATIONS: Patient authorizes AMPB to obtain, on Patient’s behalf, medical laboratories and diagnostic testing. Patient also authorizes AMPB to communicate with and to refer physicians and dispensing pharmacies about Patient and on Patient’s behalf. In addition, Patient authorizes and instructs AMPB and the physician(s) referred by AMPB and dispensing pharmacies obtained on Patient’s behalf to provide medical care and prescribe pharmaceuticals based on the Medical History Form, laboratory diagnostic tests, and other information submitted to AMPB under this Agreement. Patient acknowledges, understands and agrees that laboratory or diagnostic testing services supplied or obtained by AMPB, and medical services provided to the Patient by physician(s), are not covered or reimbursed by Medicare or other insurance.

PHYSICIAN(S): Patient acknowledges, understands and agrees that AMPB is a medical management, administration and referral service and does not direct, control or influence the medical treatment decisions made by physicians. Patient acknowledges, understands and agrees that AMPB Advisors are not licensed physicians. Patient acknowledges, understands and agrees that AMPB physicians may not be licensed to practice medicine in Patient’s state or country of residence.

MEDICAL CARE SERVICES: Patient further acknowledges, understands and agrees that AMPB and its physicians are rendering the medical care, services and treatment and that AMPB is instructed and authorized to arrange for the prescribed pharmaceuticals to be dispensed and sent to the Patient by any pharmacy in the State or County of the Patient’s residence. Patient’s prescriptions can be filled at the pharmacy of Patient’s choice.

INSTRUCTIONS AND TREATMENT: Patient acknowledges, understands and agrees to comply with the method of instructions, treatment and dosage schedules prescribed by physicians, to immediately cease any medical treatment prescribed by any physician in the event of any adverse reaction or side effect arising from prescribed treatment, and to immediately provide AMPB and its physicians with written notice via facsimile to 561.748.8315 of any such adverse reaction or side effect. Patient acknowledges, understands and agrees that diagnosis and treatment may involve certain risks, including physical and/or mental injury.

HORMONE REPLACEMENT THERAPY: Patient acknowledges, understands, and agrees that the hormone blood level objective sought as a result of Patient’s hormone replacement therapy, as by the physicians, may be at the highest level of a 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 including, but not limited to cancer or tumors. Patient is aware of the nature, risk of alternative methods of treatment and the possible consequences and/or complications involved in such hormone replacement treatment. Patient acknowledges, understands and agrees that recombinant human growth hormone replacement therapy involves the use of medical drugs approved for one purpose and are being used for 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 physicians to administer such treatment to relieve body ailments and attempt to enhance Patient’s physical condition and health. Patient further acknowledges, understands and agrees that the methods of medical treatment offered by AMPB and its physicians are not accompanied by any claims, guarantees, promises or warranties.

PRIMARY-CARE PHYSICIAN: Patient represents that he or she is under the care of a primary-care Physician and that Patient will not rely or substitute the advice of the AMPB physicians should it conflict with the advice given to Patient by

Patient's primary-care physician. Before taking any medication prescribed by AMPB physicians, Patient agrees to have a comprehensive physical examination by his or her primary-care physician and thoroughly discuss the possible side effects or negative impacts the therapy could have on his/her mind or body.

JURISDICTION: This Agreement shall be governed by and construed in accordance with the laws of the State of Florida and in the event a dispute arises between the parties in connection with any of the terms of this Lease, exclusive venue shall lie in the Circuit Court in Palm Beach County, Florida. Patient hereby irrevocably submits to the jurisdiction of such court for the purposes of any suit, civil action, arbitration or other proceeding arising out of, in connection with or with respect to this Agreement.

ATTORNEY FEES AND ARBITRATION: 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. Further, all parties agree that any dispute, conflict, or dispute shall be first submitted to binding arbitration. The Arbitrator will be agreed upon by the parties and approved by the American Arbitration Association. The cost of the Arbitration as well as any attorneys' fees will be borne equally by all parties. However, such costs and attorneys' fees shall be recovered by the prevailing party to the Arbitration.

WAIVER: Patient acknowledges, understands and agrees that AMPB is not responsible for the NEGLIGENT, GROSSLY NEGLIGENT OR INTENTIONAL ACTS OR OMISSIONS of any health-care provider or supplier to whom the Patient is referred. The total liability of AMPB, its officers, directors, employees, agents and stockholders for negligence or intentional acts is limited to the purchase price of any products through AMPB, AMPB physicians or pharmacies, and that AMPB and its physicians will not be liable for any direct, indirect, special, incidental, consequential, or punitive damages.

INDEMNIFICATION: Patient covenants and agrees to indemnify, defend, protect and hold harmless AMPB and its physicians and their respective officers, agents, 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, demands, 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, (1) AMPB and/or its physicians rendering medical care, services, advice, and/or treatment, (2) the Patient's failure to disclose all relevant information regarding Patient's medical and physical condition, (3) the acts or omissions ofAMPB or its physicians, or (4) the harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by AMPB or its physicians. Patient is aware of the potential side effects associated with the above-described treatment as Patient is obligated to discuss same with primary care physician prior to beginning therapy, accepts all risks involved in taking medication and will not seek indemnification or damages from the Indemnified Parties.

ENTIRE AGREEMENT: This Agreement represents and contains the entire agreement and understanding among the parties hereto with respect to the subject matter of this Agreement, and supersedes any and all prior oral and written agreements and understandings. No representation, warranty, condition, understanding or agreement of any kind with respect to the subject matter shall be relied upon by the parties except those contained herein. This Agreement may not be amended or modified except by an agreement signed by the party against whom enforcement of any modification or amendment is sought.

SEVERABILITY: Should any portion (word, clause, phrase, sentence, paragraph or section) of this Agreement be declared void or unenforceable, such portion shall be considered independent and severable from the remainder, the validity of which shall remain unaffected.

PATIENT UNDERSTANDING: Patient has read, understands and agrees to the terms and conditions disclosed herein, including, but not limited to the waiver and indemnification clauses for any liability(ies) arising out of hormone treatment(s) rendered by AMPB and its physicians.

Do you agree to the terms and conditions disclosed herein?*

Yes No (please circle)

Signature*_____ Name*_____

Date*_____