the HEALTH & REJUVENATION center

3345 Burns Road • Suite 204
Palm Beach Gardens, FL 3341 • 800-466-2209

MEDICAL HISTORY FORM

PLEASE COMPLETE AND FAX TO 561-340-1581

1. PERSONAL INFORMATION

Last Name: First Name: E-mail:

Address 1:

Address 2:

City: State/Province: Zip:

Country:

Home Phone: Mobile Phone: Fax:

EMPLOYMENT INFORMATION

Occupation: Employer: Phone:

Address:

City: State/Province: Zip:

2. MEDICAL INFORMATION

Date of Birth: Gender: Height: Weight:

PRIMARY PHYSICIAN INFORMATION

Physician Name Phone:

Date of last physical examination with your physician:

FAMILY HISTORY

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

If yes, please check and explain below:

Condition:	YES	NO	Condition:	YES	NO
Cardiovascular disease:	❑	❑	Lipid Disorder	❑	❑
Diabetes, thyroid or other	❑	❑	Other forms of cancer	❑	❑
Endocrine Disorder	❑	❑	Prostate cancer	❑	❑
Hypertension	❑	❑	Other illnesses	❑	❑

Please use this space to explain any YES answer and write any additional information:

LIFESTYLE INFORMATION

	YES	NO	EXPLAIN
Do You Smoke? If Yes how much do you smoke per day?	❑	❑	
Do you drink alcohol?If Yes how much do you drink per week?	❑	❑	
Are you taking over the counter supplements? If Yes, list Name and Quantity per day/week.	❑	❑	
Do you exercise regularly? If Yes, please describe your exercise routine below.	❑	❑	

2. MEDICAL INFORMATION (CONT.)

DIAGNOSED HISTORY OF DISEASE:

Do you currently have or ever had any of the following? If yes to any of the following, please explain below:

Choose Yes or No for each:	Yes	No
Any known deficiency including minerals and electrolytes	❑	❑
Blood disorders	❑	❑
Cancer	❑	❑
Carpal Tunnel syndrome	❑	❑
Orthopedic or muscle disorder including fracture or joint disorders	❑	❑
Allergies to Medications	❑	❑
Edema / excess fluid retention	❑	❑
Emotional disorders / depression	❑	❑
Genital – Urinary disorder	❑	❑
Hyperlipidemia	❑	❑
Neurological disorders, Thyroid, Diabetes or other endocrine disorder including insulin resistance, or diabetes	❑	❑

Choose Yes or No for each:	Yes	No
Use of medications: (if yes, list medications below)	❑	❑
Immune disorders	❑	❑
Chemical Dependency	❑	❑
Lung disorder	❑	❑
Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack	❑	❑
Upper respiratory	❑	❑
Poor wound healing	❑	❑
Renal disease	❑	❑
Other illnesses	❑	❑
Hypertension	❑	❑

Please explain below any YES answers for allergies to medications, surgeries, hospitalizations, disease, or any additional information:

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List all the medications you are taking: Please be specific (Name, dosage, etc.) or specify "NONE".

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Prospective Patients: Please check the symptoms you hope to have improved through hormone replacement therapy (HRT).
NOTE: THARC AND ITS PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT
Existing Patients : Please check the symptoms you have improved and hope to continue to improve through HRT.

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

If Yes, please check and explain below:	Yes	No
Decreased desire and ability to exercise	❑	❑
Cold or heat intolerance	❑	❑
Decreased energy or endurance	❑	❑
Decreased sense of well-being	❑	❑
Decreasing memory	❑	❑
	Yes	No
Decreasing muscle strength Muscle loss	❑	❑
Loss of concentration, sociability, activity	❑	❑
Depression	❑	❑
Difficulty sleeping	❑	❑
Hot flashes	❑	❑
Increased lack of drive	❑	❑
Increasing fat deposits about abdomen and/or thighs	❑	❑
Increasing mood swings	❑	❑
Other	❑	❑

	Yes	No
Increasing sagging muscles or breasts	❑	❑
Increasing wrinkles	❑	❑
Increasingly stressed	❑	❑
Decreasing size of testicals	❑	❑
Loss of interest in sex	❑	❑
	Yes	No
Progressive osteoporosis, decreasing bone mass or stooped posture	❑	❑
Sagging, loose or thin skin	❑	❑
Thinning or loss of hair	❑	❑
Urogenital atrophy	❑	❑
Headaches/ Migraines	❑	❑
Weight loss – Unexplained	❑	❑
Currently Pregnant?	❑	❑

Please use this space to explain “other” and write any additional information:

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3. TERMS AND CONDITIONS

In consideration of instructs Total Health and Rejuvenation Center. (“THARC”) providing the undersigned patient (“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”). With this Agreement, Patient submits with this Agreement an accurately completed Medical History Form (“MHF”). Patient agrees to respond to truthfully, accurately and completely in completing the MHF and acknowledges that failure to provide truthful, accurate and complete information on the MHF or to THARC or the physicians referred by THARC could result in inappropriate treatment.

Patient authorizes and THARC to obtain on my behalf medical laboratories, diagnostic testing, physicians and dispensing pharmacies. In addition, Patient authorizes and instructs THARC and physicians referred by THARC (“Physicians”) and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the MHF, laboratory diagnostic tests, and other information submitted to THARC under this Agreement. Patient agrees to present photo identification upon any blood testing pursuant to a THARC or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by THARC, and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or other insurance.

Patient acknowledges that THARC’s employees and agents are not licensed physicians and that Physicians obtained on my behalf by THARC are independent contractors, which will be compensated by Patient with funds provided to THARC. Patient acknowledges that THARC does not practice medicine and that THARC is a medical management, adminsitration and referral service and does not direct, control or influence the treatment decisions made by Physician. I further understand and agree that THARC and Physicians are rendering the medical care, services and treatment and that THARC 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 THARC and Physician with written notice via email of any such adverse reaction or side affect. I further acknowledge and agree that THARC 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 THARC 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 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. 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 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 attempt to enhance Patient’s physical condition and health. Patient further acknowledges that the methods of medical treatment offered by THARC and Physician are not accompanied by any claims, guarantees, promises or warranties.

Patient is freely seeking medical consultation via the Internet and acknowledges and consents to Physician reviewing Patient’s medical history without having the opportunity to conduct an in-person physical examination. Patient solicits THARC for a specific prescription medication to treat an already-identified medical or cosmetic 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, diagnoses, and treatments will be deemed to have occurred in Florida, where physician is licensed to practice medicine.

Patient represents that he or she is under the care of a primary care physician and that Physician will not rely or substitute the advice of Physician should it conflict with the advice given to me by Patient’s primary care physician. Before taking any medication prescribed by Physician, Patient agrees to have a comprehensive physical examination by his or her primary care physician. Patient agrees to notify his or her primary care physician and advise such physician that Patient is undergoing hormone replacement therapy.

Patient acknowledges that under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Patient acknowledges and agrees that THARC is not responsible for the negligent or intentional acts or omissions of any health care provider or supplier that Patient is referred or for any action or inaction taken by Patient, that the total liability of THARC, its officers, directors, employees, agents and stockholders is limited to the purchase price of any products through THARC, Physicians or pharmacies, and that THARC and Physicians will not be liable for any direct, indirect, special, incidental, consequential, or punitive damages. During Patients relationship with THARC and Physician, THARC and Physician will convey to Patient a range of proprietary business information, including, confidential disclosures and trade secrets business practices and THARC’s customers and suppliers (“Confidential Information”). No matter how received by Patient during the parties’ relationship, Patient agrees that Confidential Information is confidential, proprietary and uniquely valuable to THARC and gravely affects the conduct of business of THARC and THARC’s goodwill. Patient agrees not to disclose, divulge or communicate, in any fashion, form, or manner, either directly or indirectly, any of Confidential Information or take any action that may result in disclosure of Confidential Information to any third-party person, firm, or business. Patient agrees that if the terms of this paragraph are breached, THARC shall be conclusively deemed to be irreparably injured and shall be entitled to an injunction restraining Patient from disclosing any of the Confidential Information and to liquidated damages in the amount of Ten Million Dollars ($10,000,000.00). Patient agrees that the amount of THARC’s actual damages in such circumstances would be difficult, if not impossible, to determine with accuracy, but would be substantial in any event, and Patient agrees that such liquidated damages are not a penalty.

Based on the above-understanding, Patient agrees to release THARC, its officers, directors, employees, agents and shareholders, and Physician from any and all liability associated with or arising from the Physician’s consultation or from the medical, physical, behavioral or other effects of any medication or treatment that may be ordered, prescribed or purchased as a result of the Physician’s consultation.

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 Palm Beach 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 this 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 THARC 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, 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, THARC 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, acts or omissions of THARC or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by THARC 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 there from.

By signing below, I agree to the Terms and Conditions described above. I attest that I am not a professional or amateur athlete. I also attest that I am seeking treatment for legitimate purposes and not for the purposes of bodybuilding, body enhancement, or performance enhancement of any kind.

Signature   Print Name   Date