

The Health & Rejuvenation

Basic Exam

Was picture ID shown for verification? Yes <input type="checkbox"/> NO <input type="checkbox"/>

Name of Patient _____ D.O.B. _____ Sex: Male Female

Address _____
 Street City/Town State Zip Code

Family Physician _____ Date & Reason Consulted _____
 Address _____
 Street City/Town State Zip Code

Phone: W _____ H _____ C _____

Email _____ Emergency contact _____

Treatment and/or Medication Prescribed? Yes No (If Yes, give details in #8 Remarks Section)

1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for:

- | | YES | NO |
|--|--------------------------|--------------------------|
| A. Any allergies to medications? If yes, any anaphylactic symptoms, such as throat closing i.e. penicillin, bee stings. Please list. | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hayfever, spitting blood, or persistent hoarseness or coughing? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema? | <input type="checkbox"/> | <input type="checkbox"/> |

2. Have you ever:

- | | | |
|--|--------------------------|--------------------------|
| A. Had a surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been told to have an operation that wasn't performed? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Lived with someone who has had T.B. in the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Had a weight change in the past year? If yes, reason? (List below) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed | | |

forces?
 G. Ever applied for or received any pension or benefits for sickness, disability or accident?
 YES NO

3. Other than previously stated, as far as you know, have you in the last 5 years:

- | | | |
|---|--------------------------|--------------------------|
| A. Had any illness, disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Consulted any medical practitioner for any reason (including check-ups?) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any reason to feel you are not in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Are you taking any medication or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Are you allergic to any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

4. For women only:

- | | | |
|---|--------------------------|--------------------------|
| A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Any disorder of the breasts or female organs? | <input type="checkbox"/> | <input type="checkbox"/> |

5. A. Family History

Family Record	Age If Living	Condition of Health If not "Good," give details	Age At Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?

6. Do you participate in regular exercise? If yes, describe type and frequency. (list below)

7. Smoking Habits:

Do you smoke cigarettes?
 If yes, packs per day (list below)
 If non-smoker, did you ever smoke cigarettes?
 If yes, for how long, packs per day and when did you quit? (list below)

Initials _____

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

Patient may defer specific tests for multiple reasons but has that option AMA

9. Male/Date of last prostate exam _____ Normal / Abnormal Physician Name _____

10. Female/ Date of last pap smear _____ Normal / Abnormal Date of last mammogram _____ Normal / Abnormal
Physician Name _____

11. HEENT _____ **Circle appropriate** Normal/Abnormal/ Tramatic/ Atramatic (no history of head trauma)
 Heart _____ **Circle appropriate** Normal / Regular / Irregular Types of Irregularities, if any _____
 Lungs _____ **Circle appropriate** Normal / Clear to auscultation Wheezing Smoker Frequent bouts of Bronchitis
 Abdomen _____ **Circle appropriate** Normal Bowel sounds Tender to Palpation No Bowel Sounds Constipation
 Groin _____ **Deferred Circle appropriate** Normal Hernia Testicular Size---Normal Small Atrophied Tape Meas.____
 Lymph Nodes _____ **Circle appropriate** Normal Abnormal Large L and / or R Body Area Affected____
 Skin _____ **Circle appropriate** Normal Abnormal Inflamed or reddened areas at injection sites Yes / No
 Signs of infection Yes / No Edema Yes / No Pitting / Non-Pitting
 Prostate _____ **Deferred Circle appropriate** Normal Abnormal / hardened nodules / Enlarged / Asymmetric
 Injection site _____ **Circle appropriate** Normal / Abnormal / Reddened / Lump / Overuse

12. Blood Pressure 1st Reading Pulse 2nd Reading 3rd Reading
 Systolic _____ _____ _____ _____
 Diastolic _____ _____ _____ _____

If systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest.
 Then take 2 additional readings, otherwise one reading is sufficient.

13. Height _____(without shoes)
 Weight _____

14. Measurements (Males Only)
 Biceps measured @ 4" above anterior elbow crease _____
 Abdomen / Waist measured at umbilicus _____ inches

15. Chief complaint (as stated by patient):

Increase Fatigue	Decrease Energy
Mood Changes	Increase in Job Stress
Low self Esteem	Spousal Complaints of Decrease Libido
Increase Fat at mid section	Decrease of Muscle Mass
Slower recovery due to Past Injuries	Mid Life Crisis
Other significant complaints	

16. Remarks:

I.E. Small Town / Few Doctors, No Transportation, Weather Conditions, No specialist in this field, Past treatment poor results

Initials _____

Patient Authorization and Agreement

In consideration of instructs Total Health & Rejuvenation Center, Inc. DBA The Health & Rejuvenation Center ("THARC") providing the submitting 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 advisors are no 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. 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 of any such adverse reaction or side effect. 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 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 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 claims, guarantees, promises or warranties. In compliance with federal and state laws, there will be no refund given for any medication purchased from THARC.

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 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, diagnosis, 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 the 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.

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 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 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, 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, 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.

Initials _____
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