

Medical History Form

All form fields must be entered in medical form in order to send your information

How did you Hear about Us?*

Internet Magazine Friend/Referral Other

The Best Time to Contact You?

In the Morning In the Afternoon In the Evening Anytime

Section 1 Personal Information

Today's Date: _____ Your Email Address _____

Patient's Name _____

Address _____

City _____ State _____ ZIP _____

Home Number _____ Work Number _____

Cell Number _____

Section 2 Personal Medical Information

Date of Birth Month _____ Day _____ Year _____

Choose what type of therapy (select one)

HGH Therapy Testosterone Therapy BOTH

From what you have chosen, what kind of results do you expect from this type of therapy?

Sex Male Female

Weight _____ Height _____ Occupation _____

Primary Physician _____

Section 3 Family History

Cardiovascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lipid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prostate Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "Yes", please explain below:

Section 4 Past Medical History

- | | | |
|----------------------------|------------------------------|-----------------------------|
| Diabetes, Thyroid or Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Endocrine Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lipid Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiovascular Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prostate Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other Forms of Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you have a family history or early finding of the following?

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Pregnant/Lactating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Immune Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Poor Wound Healing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Edema/Excess Fluid Retention | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hyperlipidemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Upper Respiratory | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Renal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genital-Urinary Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Carpal Tunnel Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "Yes", please explain below:

Other Illnesses not noted yet:

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Chemical Dependency

Yes No

Neuralgic Disorders, Thyroid, Diabetes or other
Endocrine Disorder including insulin resistance

Yes No

EXPLAIN:

Section 5 Life Style Information

Do you Smoke?

Yes

No

If yes how many per day:

Do You Drink Alcohol?

Yes

No

If Yes how much per week:

Do You Exercise?

Yes

No

If Yes how many times per week:

Do You Take over the counter Supplements?

Yes

No

If yes what Kind:

Section 6 Question for Treatment

- | | | |
|---|------------------------------|-----------------------------|
| Previous weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of concentration, sociability, activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Increasing Mood Swings | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreasing Memory | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Increasingly Stressed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreased desire and ability to exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreased sense of well-being | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of interest in sex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty Sleeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Increased lack of drive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreasing size of testicles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urogenital Atrophy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold or Heat Intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreased energy or endurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Increasing sagging muscles or breasts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Progressive osteoporosis, decreasing bone mass or stooped posture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Increasing fat deposits around abdomen or thighs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vaginal dryness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hot Flashes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thinning or loss of hair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sagging, loose or thin skin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreasing muscle strength | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Section 7 Past Hormone Replacement Therapy Information

Have used HRT in past? Yes No

If "Yes", please explain:

Currently on HRT ? Yes No

If "Yes", please explain:

Section 8 Patient's Informed Consent and Authorization for Medical Care and Hormone Replacement Therapy

I, the undersigned patient (patient) hereby agree and expressly authorize New Age Health Solutions LLC, a Florida Limited Liability Company to secure a medical laboratory, physician and dispensing office/pharmacy to provide my diagnostic testing, medical care and if indicated, prescribed pharmaceuticals based on my completed and accurate medical history form and any laboratory diagnostic tests obtained through New Age Health Solutions LLC. I understand that New age Health Solutions LLC shall pay such physician as an independent contracting physician, to render my medical services from funds I pay to New Age Health Solutions LLC. I further understand and agree that the independent contracting physician and not New Age Health Solutions LLC are rendering the medical care, services and treatment to me. New Age Health Solutions LLC is instructed and authorized to obtain the necessary medications prescribed by said medical doctor by causing them to be dispensed directly to me and or sent to me by any pharmacy in the country of my residence. I specifically hold harmless and waive any and all claims or defenses against New Age Health Solutions LLC and or the treating medical physician selected by New Age Health Solutions LLC. I hold harmless and waive any and all claims or defenses against New Age Health Solutions LLC, its officers, members, managers, employees, agents, contractors, contracting physicians and contracting medical laboratories for any harm or injury I sustain from any act or omission of said treating medical doctor or other party. I also hold harmless and waive any and all claims or defenses against any treating and prescribing medical doctor selected by New Age Health Solutions LLC to render medical services for me for any harm or injury I sustain as a result of treatment rendered by said doctor. I also hold said treating physician harmless and waive any and all claims and defenses for injuries or illnesses I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by said doctor or from my failure to disclose all relevant facts to said doctor. I agree to immediately cease any medical treatment prescribed by said medical doctor in the event of any adverse response or side effect arising from prescribed treatment and provide immediate written notice to New Age Health Solutions LLC via phone and or fax to New Age Health Solutions LLC. I further agree to comply with prescribing instructions for use of medications.

I, the undersigned patient, understand and acknowledge that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks or injury. I acknowledge that no promises, assurances or guarantees have been made to me as to the results of diagnostic testing, analysis of test results, examination of medical history or treatment by New Age Health Solutions LLC or any treating or prescribing medical doctor provided to me by New Age Health Solutions LLC. I understand that the hormone blood level objective sought to result from my hormone replacement therapy, as prescribed by my treating medical doctor may be the highest level of standard reference range for my sex and age, or an even higher hormone blood levels normally found in a person younger than my self. I understand that hormone replacement therapy for the purpose of elevating my hormone blood levels to the highest level of standard reference range for my age and sex, or above such range to the levels of a younger person, is experimental and may not render any benefits, but may result in unknown adverse results.

I am aware of the nature, risk, possible alternative methods of treatment, possible consequences, and possible complications involved in my treatment. In understand that recombinant human growth hormone replacement for adults involves the use of a medical drug approved for one purpose for a new and different purpose in an effort to obtain sought objective of medical treatment. Nevertheless, I consent to such care and treatment, and I execute this form with complete informed understanding and for the purpose of authorizing the medical doctor obtained for me by New Age Health Solutions LLC to administer to me for the relief of my body ailments and to enhance my physical condition and health. I consent to receipt of foreign-related versions of any prescribed drug approved for medical use in the country of my residence. I understand that the methods of medical treatment offered or provided are not accompanied by any claims, guarantees or promises. I agree to present my photo identification at any

time my blood is drawn pursuant to New Age Health Solutions LLC test requisition.

I understand that medical information revealed by me may be used for continued medical research purposes, but that I will not be personally identified at any time. I understand that a prescribed drug ordered by me from New Age Health Solutions LLC may be dispensed to me by a pharmacy in my country.

I understand that New Age Health Solutions LLC and doctors obtained to provide medical treatment have elected not to carry malpractice insurance due to the unique and unconventional medical treatments designed primarily to be preventative and non-invasive. With respect to any Florida medical doctors rendering or prescribing my treatment at the request of New Age Health Solutions LLC this notice is provided pursuant to S.458 320 Florida Statute. I expressly agree that the jurisdiction and venue for any medical claim, legal or equitable claim or any type whatsoever, or any dispute regarding pharmaceuticals, physicians, physicians services, medical laboratories, or any services or products provided to me by New Age Health Solutions LLC its contracting pharmacies or any services rendered by any medical doctor it selects for me shall be exclusively in Palm Beach County, Florida. I consent to the transfer and removal of any claim or action brought by me against New Age Health Solutions LLC, its officers, members, managers, employees, agents, contractors, contracting physicians and contracting medical laboratories to binding arbitration in Florida. Further, I agree to pay all costs and reasonable attorney's fees incurred by any party against whom I bring a claim or action in violation of the terms of this instrument or related to the transfer, removal, change of venue of any claim brought by me against any party to venue as such costs are incurred on a weekly basis, without exception or assertion of any legal or equitable defense on my part or any legal counsel obtained to represent me. Jurisdiction and venue for any action brought against me by New Age Health Solutions LLC, its officers, members, managers, employees, agents, contractors, contracting physicians or contracting laboratories shall be in Palm Beach County, Florida, USA.

The pharmaceuticals and laboratories blood testing services supplied by New Age Health Solutions LLC and medical services provided to me by treating medical doctors may or may not be covered or reimbursed by Medicare or other insurance. In any case, New Age Health Solutions LLC will not submit insurance claims on behalf of the patients.

In consideration of New Age Health Solutions LLC undertaking to render the undersigned patient any administrative or any other services in any way to this agreement, or New Age Health Solutions LLC disclosing information or methods of treatment to patient (either of which are deemed sufficient consideration for this agreement), then, in the event any court determines that the undersigned patient sought medical treatment or medical prescriptions through New Age Health Solutions LLC for possible or apparent purpose, directly or indirectly, of deception, assisting any investigation, or the rendering of any type of assistance to, or disclosing any information pertaining to New Age Health Solutions LLC, its procedures, officers, members or medical protocols, to any news organization, possible or actual competitor, any type of governmental agency, any investigator or any other party for the possible or apparent purpose of securing any information, confidential or otherwise, about New Age Health Solutions LLC, its officers, members, managers, affiliates, banking relationships, contractors, contracting medical laboratories, contracting physicians, medical protocols, sources of pharmaceuticals, proprietary medical treatment protocols or New Age Health Solutions LLC, system of pharmaceuticals procurement, distribution, and dispensing, then the undersigned patient knowingly, expressly and irrevocably consents to a judgment in favor of New Age Health Solutions LLC, its officers/members or any party proceeding under the authority of this instrument, of liquidated damages, jointly and serially against the undersigned patient, as well as, any express or apparent principal of patient (including patient's employer) as an authorized or apparent agent of his principal or employer, in the amount of Five Million Dollars, (\$5,000,000.00), which liquidated damage amount is hereby accepted by the undersigned as a reasonable amount for engaging in any such acts or deception and because they are difficult to ascertain. The undersigned patient engaged in such deception or any of the above described acts, agrees on behalf

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of himself and his principal, to pay all reasonable attorneys' fees costs incurred by any person or entity to enforce this agreement.

I agree to pay all reasonable attorneys fees and costs incurred by New Age Health Solutions LLC or Treating Physician seeking to enforce this agreement. This agreement represents the complete and entire agreement between the parties to it.

Last 4 digits of Social Security Number _____

Patient E-mail _____

Do you agree to the terms and conditions disclosed here in? Yes No