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:	

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	Explain family health history:
* 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	

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	* Edema / excess fluid retention:	◯ Yes	◯ No
* Use of medications (if yes, list medications below):	◯ Yes	◯ No	* Poor wound healing:	◯ Yes	◯ No
			* Emotional disorders / depression:	◯ Yes	◯ No
* Blood disorders:	◯ Yes	◯ No	* Renal disease:	◯ Yes	◯ No
* Immune disorders:	◯ Yes	◯ No	* Genital - Urinary disorder:	◯ Yes	◯ No
* Cancer:	◯ Yes	◯ No	* Hyperlipidemia:	◯ Yes	◯ No
* Chemical Dependency:	◯ Yes	◯ No	* Hypertension:	◯ Yes	◯ No
* Carpal Tunnel syndrome:	◯ Yes	◯ No	* Neurological disorders:	◯ Yes	◯ No
* Lung disorder:	◯ Yes	◯ No	* Thyroid, Diabetes or other endocrine disorder including insulin resistance:	◯ Yes	◯ No
* Orthopedic or muscle disorder including fracture or joint disorders:	◯ Yes	◯ No	* Arthritis:	◯ Yes	◯ No
* Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack:	◯ Yes	◯ No	* Bursitis:	◯ Yes	◯ No
			* Rheumatism:	◯ Yes	◯ No
* Allergies to Medications:	◯ Yes	◯ No	* Sports Injury(s):	◯ Yes	◯ No
* Upper respiratory:			* 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	Type/Dose/Frequency:
Deca:	◯ Yes	◯ No	
Winstrol:	◯ Yes	◯ No	
hGH:	◯ Yes	◯ No	Type/Dose/Frequency:
Thyroid:	◯ Yes	◯ No	
Other:	◯ Yes	◯ No	

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.

ATLANTA MEN'S CLINIC AND ITS PHYSICIANS/NURSE PRACTITIONERS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT. We do not treat bodybuilders. 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	* Currently Pregnant:	◯ Yes	◯ No
* Increasing fat deposits around the abdomen and/or thighs:	◯ Yes	◯ No	* Depression:	◯ Yes	◯ No
* Increasing mood swings:	◯ Yes	◯ No	* Difficulty sleeping:	◯ Yes	◯ No
* Increasing sagging muscles or breasts:	◯ Yes	◯ No	* Headaches / Migraines:	◯ Yes	◯ No
* Increasing wrinkles:	◯ Yes	◯ No	* Hot flashes:	◯ Yes	◯ No
* Increasingly stressed:	◯ Yes	◯ No	* Loss of concentration, sociability, activity:	◯ Yes	◯ No
			* Loss of interest in sex:	◯ Yes	◯ No

* Decreased desire and ability to exercise:	◯ Yes	◯ No	* Muscle loss:	◯ Yes	◯ No
* Decreased energy or endurance:	◯ Yes	◯ No	* Sagging, loose or thin skin:	◯ Yes	◯ No
* Decreased sense of well-being:	◯ Yes	◯ No	* Sore Muscles, join pain(s) or swelling:	◯ Yes	◯ No
* Decreasing memory:	◯ Yes	◯ No	* Thinning or loss of hair:	◯ Yes	◯ No
* Decreasing muscle strength:	◯ Yes	◯ No	* Urogenital atrophy:	◯ Yes	◯ No
* Decreasing size of testicles:	◯ Yes	◯ No	* Weight loss - Unexplained:	◯ Yes	◯ No
* Progressive osteoporosis, decreasing bone mass or stooped posture:	◯ Yes	◯ No	* Other:	◯ Yes	◯ No
* Cold or heat intolerance:	◯ 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 Atlanta Men's Clinic, LLC ("Physicians") 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 Atlanta Men's Clinic, LLC (“Physicians”) could result in inappropriate treatment. Patient authorizes Atlanta Men's Clinic 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 Atlanta Men's Clinic, Physicians and Nurse Practitioners, 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 Atlanta Men's Clinic under this Agreement. Patient agrees to present photo identification upon receiving any blood testing pursuant to a Atlanta Men's Clinic or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by Atlanta Men's Clinic, and medical services provided to me by Physicians or Nurse Practitioners, may 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 Atlanta Men's Clinic and/or Physician/Nurse Practitioner for the purpose of athletic or performance or cosmetic enhancement. It is outside the scope of Atlanta Men's Clinic and the Physician/Nurse Practitioner to provide these services or prescriptions under those circumstances. Atlanta Men's Clinic and the Physician/Nurse Practitioner 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/Nurse Practitioner.

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

Patient acknowledges that diagnosis and treatment may involve risk of injury, and that Atlanta Men's Clinic and Physician/Nurse Practitioner 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/Nurse Practitioner, 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/Nurse Practitioner to administer such treatment to relieve body ailments and deficiencies. Patient further acknowledges that the methods of medical treatment offered by Atlanta Men's Clinic and Physician/Nurse Practitioner are not accompanied by claims, guarantees, promises or warranties. In compliance with federal and state laws, there will be no refund given for any treatment.

Patient is freely seeking medical consultation and acknowledges and consents to Physician/Nurse Practitioner reviewing Patient's medical history with the opportunity to conduct an in-person physical examination prior to any treatment. Patient acknowledges that Physician/Nurse Practitioner is licensed to practice medicine in Patient's state or country of residence. Further, Patient agrees that Physician/Nurse Practitioner consultations, diagnosis, and treatments will be deemed to have occurred in Georgia.

Patient represents that he or she is under the care of a primary care physician, and he or she will not rely or substitute the advice of Physician/Nurse Practitioner should it conflict with the advice given by Patient's primary care physician. Before qualifying for any treatment or any medication prescribed by Physician/Nurse Practitioner, Patient agrees to have a comprehensive physical examination and to submit same to become a part of patient's records to be maintained by Atlanta Men's Health. 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 Georgia, 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 Fulton County, Georgia 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 sever-able.

Patient covenants and agrees to indemnify, defend, protect and hold harmless Atlanta Men's Clinic and Physician/Nurse Practitioner 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, Atlanta Men's Clinic and/or Physician/Nurse Practitioner 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 Atlanta Men's Clinic or Physician/Nurse Practitioner, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Atlanta Men's Clinic or Physician/Nurse Practitioner. 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 Atlanta Men's Clinic, the entire Staff at Atlanta Men's Clinic and the prescribing Physician/Nurse Practitioner 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 have been 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 Atlanta Men's Clinic and discontinue use until advised to resume usage by Atlanta Men's Clinic Physician/Nurse Practitioner. ☐

* I understand that Atlanta Men's Clinic does not take any insurance. I agree to pay cash for my medication/treatment. I can request documentation to personally process 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. ☐

* 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:	

Please complete forms and fax to 1-844-350-6954 or email to contact@atlantamensclinic.com

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