MEDICAL HISTORY FORM

Please complete the following Medical History Form ensuring that your answers are accurate. This information will be stored on our secure database. You will be contacted after one of our clinical advisers will revise your information.

PRIME HORMONES.COM

*Required field

Section 1: **PESRONAL INFORMATION**

*Name :	First	M.I	Last	
*E-mail :			Cell Phone:	
*Driver License :			Hours to call :	
*Address :			Home Phone:	
*City :			Hours to call :	
*State :			Work Phone:	
*Zip Code :			Hours to call :	
*Country :				
*Occupation :	USA			

Have you already contacted PRIME Hormones ? Please provide adviser's name:

Section 2: **MEDICAL HSTORY**

GENERAL

*Date of birth : MM / DD / YY

* Weight:

*Gender : ◯ Male ◯ Female

* Height:

PRIMARY PHYSICIAN INFORMATION

Physicians Name :

Phone:

Date of last physical exam with above physician: MM / DD / YY

Last Colonoscopy Date:

Last Prostate Exam:

Vasectomy: ◯ Yes ◯ No

FAMILY HISTORY

Does any immediate family member currently have or ever had any of the following?
Please check below (Yes or No) and if you chose Yes then explain in the explanation field:

Explain family health history:

Cardiovascular disease:	◯ Yes	◯ No
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
Blood disorders:	◯ Yes	◯ No	*Emotional disorders / depression:*	◯ Yes	◯ No
Immune disorders:	◯ Yes	◯ No	*Renal disease:*	◯ Yes	◯ No
Cancer:	◯ Yes	◯ No	*Genital - Urinary disorder:*	◯ Yes	◯ No
Chemical Dependency:	◯ Yes	◯ No	*Hyperlipidemia:*	◯ Yes	◯ No
Carpal Tunnel syndrome:	◯ Yes	◯ No	*Hypertension:*	◯ Yes	◯ No

Lung disorder:	◯ Yes	◯ No	*Neurological disorders:*	◯ Yes	◯ No
Orthopedic or muscle disorder including fracture or joint disorders:	◯ Yes	◯ No	*Thyroid, Diabetes or other endocrine disorder including insulin resistance:*	◯ Yes	◯ No
Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack:	◯ Yes	◯ No	*Arthritis:*	◯ Yes	◯ No
Allergies to Medications:	◯ Yes	◯ No	*Bursitis:*	◯ Yes	◯ No
Upper respiratory:	◯ Yes	◯ No	*Rheumatism:*	◯ Yes	◯ No
Sports Injury(s):	◯ Yes	◯ No	*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"**:

STEROIDS

Prior history of Steroids or hormones? ◯ Yes ◯ No

If yes, please select:

Male

Test:	◯ Yes	◯ No	Type/Dose/Frequency:
Deca:	◯ Yes	◯ No	Last used:
Winstrol:	◯ Yes	◯ No	
HGH:	◯ Yes	◯ No	Prior Medical Records / Labs? ◯ Yes ◯ No Any side affects?
Thyroid:	◯ Yes	◯ No	
Other	◯ Yes	◯ No	Used estrogen-blocker? ◯ Yes ◯ No

QUESTIONS FOR TREATMENT

New 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.

PRIME Hormones AND IT'S PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT. We do not treat bodybuilders or professional athletes. 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?
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
Decreased desire and ability to exercise:	◯ Yes	◯ No	*Loss of interest in sex:*	◯ Yes	◯ No
Decreased energy or endurance:	◯ Yes	◯ No	*Muscle loss:*	◯ Yes	◯ No
Decreased sense of well-being:	◯ Yes	◯ No	*Sagging, loose or thin skin:*	◯ Yes	◯ No
Decreasing memory:	◯ Yes	◯ No	*Sore Muscles, join pain(s) or swelling:*	◯ Yes	◯ No
Decreasing muscle strength:	◯ Yes	◯ No	*Thinning or loss of hair:*	◯ Yes	◯ No
Decreasing size of testicles:	◯ Yes	◯ No	*Urogenital atrophy:*	◯ Yes	◯ No
Progressive osteoporosis, decreasing bone mass or stooped posture:	◯ Yes	◯ No	*Weight loss - Unexplained:*	◯ Yes	◯ No
Cold or heat intolerance:	◯ Yes	◯ No	*Other:*	◯ Yes	◯ No

Please use this space to explain any additional information:

Section 3: **SIGNATURE**

Patient Authorization - Agreement and Consent to Care Form

By signing this Patient Authorization/Agreement and Consent to Care Form (“Agreement”), the undersigned, as or on behalf of Patient ("Patient") authorizes and instructs PRIME Hormones ("PRIME Hormones") to provide Patient with the managing, administration and referral of medical services. Patient acknowledges and agrees to the terms and conditions as set forth herein. Patient is aware and agrees that Patient is responsible for submitting an accurately and truthfully completed Medical History Form ("MHF") in conjunction with this Agreement. Patient understands and acknowledges that failure to provide accurate and truthful information on the MHF and/or to the physicians referred by PRIME Hormones ("Physicians") could result in inappropriate and/or inaccurate treatment.
Patient authorizes PRIME Hormones to communicate with and receive copies of reports completed by medical laboratories, diagnostic testing facilities, Physicians and dispensing pharmacies in regard to Patient’s diagnoses and treatment. In addition, Patient authorizes and instructs PRIME Hormones, all Physicians and dispensing pharmacies obtained on the behalf of Patient, to provide medical care and prescribed pharmaceuticals, based on the information contained within the MHF, and/or any laboratory or diagnostic tests, and/or any other information obtained by PRIME Hormones under this Agreement. Patient agrees to prove Patients’ identity, by presenting photo identification, before receiving any blood testing in consideration of a PRIME Hormones or Physician test requisition.
Patient further understands and agrees that PRIME Hormones and Physicians are rendering medical care, services and treatment, and that patient by and thru this Agreement, instructs and authorizes PRIME Hormones to arrange for the prescribed pharmaceuticals to be dispensed and sent to Patient by any pharmacy in Patient’s country of residence. Patient understands and acknowledges that PRIME Hormones’s employees and clinical advisers are not licensed physicians, and that Physicians referred and/or obtained by PRIME Hormones on behalf of Patient, are independent contractors, which are to be compensated by Patient with funds that are provided to PRIME Hormones. Patient understands, acknowledges, and agrees that any and all therapy, laboratory and/or diagnostic testing services supplied and/or obtained by PRIME Hormones on the behalf of Patient, and any and all medical services provided to Patient by Physicians, are not covered or reimbursable thru Medicare or any other type of health insurance plan.

Patient specifically swears and acknowledges that Patient is not a professional (or an amateur) athlete or bodybuilder; Patient is not seeking treatment or prescription medication from PRIME Hormones and/or Physician for the purpose of athletic, cosmetic, or performance enhancement; It is outside the scope of PRIME Hormones and Physician to provide services or prescriptions under those circumstances; and PRIME Hormones and Physician only provide treatment and/or prescription medication to patients whom it has determined, by laboratory blood tests, physical examination, the MHF and/or the sole determination of the Physician, to have a deficiency and medical need for such treatment and/or prescription medication.

Patient covenants and agrees to follow the instruction, treatment and dosage schedules prescribed by Physician; in the event of any adverse reaction or side effect arising from any prescribed medical treatment by Physician, to immediately cease said treatment; and to immediately provide written notice of any such adverse reaction or side effect to PRIME Hormones and Physicians.

Patient understands, acknowledges and agrees that diagnosis and treatment may involve risk of injury, and that PRIME Hormones and Physician have not made any guarantees or warranties regarding any diagnostic testing, the analysis of test results, examination of medical history, or hormone treatment. Patient further acknowledges and agrees that PRIME Hormones is not liable for any negligent act or omission of the Physician. Patient acknowledges that the objective hormone blood level sought by Physician, 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, could be above such range, equaling the level of a younger person, and that such range is experimental and may not produce any benefits, but could result in unknown, adverse results.

Patient is aware of the nature, the risk, and possible alternative methods of treatment, the possible consequences and/or complications involved in hormone replacement treatment. Patient acknowledges that recombinant human growth hormone replacement therapy involves the use of a medical drug approved for one purpose, which is being used for a new and different purpose, in an effort to achieve the desired objective of medical treatment. Nonetheless, Patient consents to such care and treatment, and executes this Agreement with a complete and informed understanding of such hormone replacement therapy for the purpose of authorizing Physician to administer such treatment to relieve body ailments and deficiencies.

Patient further acknowledges that the methods of medical treatment offered by PRIME Hormones and physicians are not accompanied by claims, guarantees, promises or warranties. In compliance with federal and state laws, there are no refunds given for any medication.

Patient is freely seeking medical consultation via the internet and in consideration of the same, understands, acknowledges and consents to Physician reviewing Patient's medical history without the opportunity to have a physical examination conducted in person. Patient has freely contacted PRIME Hormones to arrange for a specific prescribed medication, in Patients effort to treat a medical condition that has already been identified. Patient represents that Patient is under the care of the Physician, in conjunction and simultaneously with a primary care physician, and Patient will not rely on or substitute the advice of Physician should it be in conflict with advice given by Patient's primary care physician. Patient agrees to notify Patient's primary care physician and inform said physician that Patient is undergoing hormone replacement therapy. Before qualifying and receiving authorization for any treatment or medication prescribed by Physician, Patient agrees to have a comprehensive physical examination, which Patient will submit to become a part of patient's permanent records to be maintained by PRIME Hormones.

Patient understands and acknowledges that Physician may or may not be licensed to practice medicine in Patient's state or country of residence. Furthermore, Patient agrees that Physician's consultations, diagnosis, and treatments will be deemed to have occurred under the jurisdiction of the state of Florida, USA. 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 County of Broward, within the State of 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, so that any invalid or unenforceable provision of this Agreement shall be removed and have no effect on the remaining provisions of this Agreement.

Patient covenants and agrees to indemnify, defend, protect and hold harmless PRIME Hormones and physicians 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, PRIME Hormones and/or physician's rendering medical care, services, advice and/or treatment.

Patient's failure to disclose all pertinent information regarding Patient's medical and/or physical condition, may result in acts or omissions by PRIME Hormones or physicians, which may result in harm or injury due to medical care or pharmaceuticals provided directly or indirectly by PRIME Hormones or physicians. Patient is aware of potential side effects associated with the treatment described above, and by executing this Agreement accepts all risks involved in taking medication as part of said treatment and agrees that Patient will not seek indemnification or damages from the Indemnified Parties herein.

Liability Waiver and Hold Harmless: I, the undersigned, voluntarily elect to undergo hormone replacement therapy. All potential risks and side effects have been completely and thoroughly explained to me. I acknowledge and understand those risks. However, I have assessed the potential risks on a personal basis, and I believe the benefits of hormone replacement therapy outweigh the risks (including the chance of elevated prostate levels which some physicians hypothesize could potentially lead to prostate cancer). I hereby release and agree to hold harmless PRIME Hormones, the entire staff PRIME Hormones and any prescribing physician associated with my hormone replacement therapy. I have had sufficient time to consider all options and have researched various 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 I have purchased are 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 PRIME Hormones and discontinue use until advised to resume usage by PRIME Hormones. ☐

*I will safeguard my medications from loss or theft. ☐

*I understand that PRIME Hormones does not cooperate with any insurance companies. If any part of my prescription from PRIME Hormones's physicians is to be picked up at a local pharmacy, I agree to pay cash for that medication. I will not request that it be processed 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, and I will keep the medications in its respective labeled container. ☐

*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. ☐

***Digital signature please PRINT YOUR FULL NAME:**

SAVE this PDF to your computer and send it from your e-mail to info@primehormones.com

Our medical assistants will call you back, to assist you with your hormone replacement therapy.