6856 Eastern Ave NW Suite 205
Washington, DC 20012
800-881-4428
www.prcindc.com

COMPLETE MEDICAL HISTORY QUESTIONNAIRE

This questionnaire is for confidential medical evaluation only. Your true and accurate medical history is required for the Doctor to issue you prescriptions. A copy of your driver's license is also required.

Please use the last page of the questionnaire if you need more space to answer a question.

Patient Name: _____ Date of Birth (DOB): _____

Phone Number: _____

How did your hear about us? Name of Friend/Referral: _____ ☐ Internet ☐ Ad Other: _____

_____

What are your primary goals / desires / expectations from your treatment? :_____

_____

_____

_____

_____

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History of Present Illness:

Please Check: Do you have or have you ever had any of the following? If "yes" explain on the last page of the questionnaire.

Past Medical History	*YES*	*NO*
Cold or heat intolerance	_____	_____
Decreased memory	_____	_____
Increased Wrinkles	_____	_____
Muscle loss	_____	_____
Decreased sex drive	_____	_____
Decreased desire/ ability to exercise	_____	_____
Difficulty sleeping	_____	_____
Hot flashes/flushes	_____	_____
Lack of drive	_____	_____
Increased body fat	_____	_____
Mood swings	_____	_____
Progressive Osteoporosis (decreased bone mass /stooped posture)	_____	_____
Sagging muscles or breasts	_____	_____
Loss of concentration	_____	_____
Decreased energy /endurance (which?)	_____	_____
Decreased sense of well being	_____	_____
Decreased muscle strength	_____	_____
Decreased testicle size	_____	_____
Stooped Posture	_____	_____
Loose or thin skin	_____	_____

Female Patient Questions:

Vaginal dryness		_____	_____
Weight loss / gain		_____	_____
Currently pregnant		_____	_____
Irregular periods		_____	_____
PMS		_____	_____
Experiencing Menopause	Starting Date: _____	_____	_____
Last Menstrual Period	Date: _____		

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Medications: Please list ALL medications by name and dosage (including supplements):

_____

_____

_____

_____

Drug Allergies: Please list name of drug and your reaction to it.

_____

_____

_____

Past Medical History: Please list hospitalizations, operations and any other significant illness with dates.

Operations:

Hospital: _____ Operation: _____ Date: _____
Hospital: _____ Operation: _____ Date: _____
Hospital: _____ Operation: _____ Date: _____
Hospital: _____ Operation: _____ Date: _____

Illnesses:

Hospital: _____ Illness: _____ Date: _____
Hospital: _____ Illness: _____ Date: _____
Hospital: _____ Illness: _____ Date: _____
Hospital: _____ Illness: _____ Date: _____

Other illnesses:

Illness: _____ Date of Diagnosis: _____
Illness: _____ Date of Diagnosis: _____
Illness: _____ Date of Diagnosis: _____
Illness: _____ Date of Diagnosis: _____

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Family History: Are there any of the following in the family? If any answers are checked "Yes", please explain.

SYMPTOM	*YES*	*NO*	*RELATIVE(S) & DESCRIPTION*
Cardiovascular Disease	_____	_____	_____
Diabetes	_____	_____	_____
Hypertension	_____	_____	_____
Lipid Disorder	_____	_____	_____
Breast Cancer	_____	_____	_____
Prostate Cancer	_____	_____	_____
Other Cancer(s)	_____	_____	_____
Other Illness	_____	_____	_____
			_____
			_____
			_____
			_____
			_____
			_____
			_____

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Social History:	*YES*	*NO*	*AMOUNT*
Do you smoke? If "yes" how many cigarettes/ and or packs per day?	____	____	_____
Do you drink? If "yes" how many drinks per day /and or per week?	____	____	_____
Do you exercise? If "yes" how often?	____	____	_____
Do you use artificial sweetners or drink diet beverages	____	____	_____
Are you in the Military/Police/Fire&Rescue?	____	____	_____
Are you a professional athlete?	____	____	_____
Are you a former professional athlete?	____	____	_____
Are you an Olympic athlete?	____	____	_____
Are you a former Olympic athlete?	____	____	_____
Do you check labels for trans fat?	____	____	_____
Do you use extra virgin olive oil as your primary oil?	____	____	_____
Do you avoid sugar?	____	____	_____
Do you avoid processed foods?	____	____	_____
Do you consume water daily?	____	____	_____

Sleep:

How many hours do you sleep at night? ___3___4___5___6___7___8+		
Lights completely off?	____	____
Do you turn off TV 2 hours before sleep?	____	____
Is it hard for you to fall asleep?	____	____
Do you wake up early or multiple waking up?	____	____
Are you refreshed upon waking up?	____	____

Hormonal : (please check one or both)

If Male would you like improvement of libido ___ or erection ____?
If Female would you like improvement with libido _____ or lubrication ____?

Metabolic:

Do you feel good about your body image and weight?	____	____

I usually feel ___Cold ___Hot ___Just right ___Other : _____
Energy level which describes you best, most of the time: __0__1__2__3__4__5__6__7__8__9__10

Head Trauma:

Any history of car accident, head trauma (even mild jarring) ,etc ?	____	____

Mood:

I usually feel : ___flat___anxious__depressed__irritable__foggy__other _____

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Patient History:

Do you have or have you ever had any of the following? If "yes" explain in area below.

SYMPTOM	*YES*	*NO*
Any known deficiencies including minerals and electrolytes	_____	_____
Blood disorders	_____	_____
History of cancer	_____	_____
Carpal tunnel syndrome	_____	_____
Chemical dependency	_____	_____
Drug allergies	_____	_____
Edema/ excess fluid retention	_____	_____
Emotional disorders/ depression	_____	_____
Genital /urinary disorders	_____	_____
Glaucoma	_____	_____
Heart disease/ attack	_____	_____
Hyperlipidemia/ high cholesterol	_____	_____
Hypertension	_____	_____
Immune disorders	_____	_____
Lactating	_____	_____
Lung disorders	_____	_____
Neurological disorders-thyroid, diabetes or other	_____	_____
Endocrinological disorders including insulin resistance	_____	_____
Orthopedic or muscle disorder-fracture or joint disorders	_____	_____
Poor wound healing	_____	_____
Osteoporosis	_____	_____
Renal / kidney disease	_____	_____
Upper respiratory problems	_____	_____

Please explain below any of the answers that you answered "YES" to above:

_____

_____

_____

please use the next page if you need more room for any additional detail or explanation regarding your health history*

I hereby affirm that the information I have provided on this form is true and accurate and to the best of my knowledge.

_____ _____

Signature of Patient Date

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Please use this space if you have any additional details or explanation not mentioned above regarding your health history.

In consideration of Physicians Rejuvenation Centers in DC, LLC. ("PRCINDC") providing the undersigned patient

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("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 PRCINDC or the physicians referred by PRCIDC could result in inappropriate treatment.

Patient authorizes PRC to obtain on my behalf medical laboratories, diagnostic testing, physicians and dispensing pharmacies. In addition, Patient authorizes and instructs PRCINDC and physicians referred by PRCINDC ("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 PRCINDC under this Agreement. Patient agrees to present photo identification upon any blood testing pursuant to a PRCINDC or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by PRCINDC, and medical services provided to me by Physicians, are not covered or reimbursed by Medicare or other insurance.

Patient acknowledges that PRCINDC's employees and agents are not licensed physicians and that Physicians obtained on my behalf by PRCINDC are independent contractors, which will be compensated by Patient with funds provided to PRCINDC. Patient acknowledges that PRCINDC does not practice medicine and that PRCINDC is a medical management, administration and referral service and does not direct, control or influence the treatment decisions made by Physician. I further understand and agree that PRCINDC and Physicians are rendering the medical care, services and treatment and that PRCINDC 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 PRCINDC and Physician with written notice via fax to 888-881-3412or email of any such adverse reaction or side affect. I further acknowledge and agree that PRCINDC 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 PRCINDC 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

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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 PRCINDC 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 PRCINDC 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 Washington, DC, 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 Washington, DC law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Patient acknowledges and agrees that PRCINDC 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 PRCINDC, its officers, directors, employees, agents and stockholders is limited to the purchase price of any products through PRCINDC, Physicians or pharmacies, and that PRCINDC and Physicians will not be liable for any direct, indirect, special, incidental, consequential, or punitive damages. During Patients relationship with PRCINDC and Physician, PRCINDC and Physician will convey to Patient a range of proprietary business information, including, confidential disclosures and trade secrets business practices and PRCINDC'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 PRCINDC and gravely affects the conduct of business of PRCINDC and PRCINDC'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, PRCINDC 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. Patient agrees that the amount of PRCINDC'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 PRCINDC, 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 District of Columbia,

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applicable to agreements made and to be performed entirely within such District, 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 Washington, DC 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 PRCINDC 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, PRCINDC 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 PRCINDC or Physician, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by PRC IINDC 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.

I attest that I am here for age management services

I attest that I am not a professional athlete

I attest that I am not looking for body enhancement

I attest that I am not looking for aesthetic enhancement

I have completed the medical history form to the best of my knowledge. I certify that my answers are complete, honest and true.

Signed: Date: Submit