Medical History Form

SECTION 1. PERSONAL INFORMATION

Name:	Date:
Email:	Social Security #:
ADDRESS	**PHONE NUMBERS** Best Available
Street:	Home: ❑
	Work: ❑
	Mobile: ❑
	Fax:
City:	State/Province:
Zip:	Country:
Occupation:	

SECTION 2. CONFIDENTIAL MEDICAL HISTORY

MEDICAL HISTORY INFORMATION

Date of Birth:	Weight:
Gender:	Height:

PRIMARY PHYSICIAN INFORMATION

Physicians Name:	Phone:

Date of your last physical examination with your physician?:

Family History: Does an immediate family member currently have or ever had any of the following? If yes, please check and explain below:

	Yes	No		Yes	No
Cardiovascular disease:			Lipid Disorder		
Diabetes, thyroid or other			Other forms of cancer		
Endocrine Disorder			Prostate cancer		
Hypertension			Other illnesses		

Please use this space to explain any Yes answer and write any additional information:

Lifestyle Information

	Yes	No	
Do You Smoke?			If Yes how much do you smoke per day?
Do you drink alcohol?			If Yes how much do you drink per week?
Are you taking over the counter supplements?			If Yes, list Name and Quantity per day/week:

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Do you exercise regularly?			If Yes, please describe:

Diagnosed History of Disease: Do you currently have or ever had any of the following? If yes, please explain in the box below:

Choose Yes or No for each:	Yes	No	Choose Yes or No for each:	Yes	No
Any known deficiency including minerals and electrolytes			Use of medications: (if yes, list medications below)		
Blood disorders			Immune disorders		
Cancer			Chemical Dependency		
Carpal Tunnel syndrome			Lung disorder		
Orthopedic or muscle disorder including fracture or joint disorders			Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack		
Allergies to Medications			Upper respiratory		
Edema / excess fluid retention			Poor wound healing		
Emotional disorders / depression			Renal disease		
Genital – Urinary disorder			Other illnesses		
Hyperlipidemia			Hypertension		
Neurological disorders, Thyroid, Diabetes or other endocrine disorder including insulin resistance, or diabetes					

Please use this space to explain any Yes answers for allergies to medications, surgeries, hospitalizations, disease, or any additional information:

List all the medications you are taking: Please be specific (Name, dosage, etc.)

Prospective Patients: Please check the symptoms you hope to have improved through hormone replacement therapy (HRT).

NSI **AND ITS PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT**

Existing Patients: Please check the symptoms you have improved and hope to continue to improve through HRT.

Questions for Treatment: Do you currently have or ever had any of the following symptoms? If Yes, please check and explain below:

	Yes	No		Yes	No
Decreased desire and ability to exercise			Increasing sagging muscles or breasts:		
Cold or heat intolerance			Increasing wrinkles		
Decreased energy or endurance			Increasingly stressed		
Decreased sense of well-being			Decreasing size of testicals		
Decreasing memory			Loss of interest in sex		

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	Yes	No		Yes	No
Decreasing muscle strength			Muscle loss		
Loss of concentration, sociability, activity			Progressive osteoporosis, decreasing bone mass or stooped posture		
Depression			Sagging, loose or thin skin		
Difficulty sleeping			Thinning or loss of hair		
Hot flashes			Urogenital atrophy		
Increased lack of drive			Headaches/ Migraines		
Increasing fat deposits about abdomen and/or thighs			Weight loss – Unexplained		
Increasing mood swings			Currently Pregnant?		
Other					

Please use this space to explain "other" and write any additional information:

(this section is for notes)

PATIENT'S AGREEMENT & RELEASE

THIS AGREEMENT is made and executed on the ______ day of _______ 200___, between Nationwide Synergy, Inc. (hereinafter referred to as "NSI") and __________________________ (hereinafter referred to as "Patient").

IN CONSIDERATION of the Nationwide Synergy, Inc., providing Patient with medical management, administrative and referral services, Patient acknowledges, understands and agrees to the following terms and conditions as set forth herein.

MEDICAL HISTORY FORM: Patient will submit an accurately completed Medical History Form. Patient agrees to truthfully, accurately and completely respond in completing this form and acknowledges, understands and agrees that failure to provide truthful, accurate and complete information on this form to NSI or to the "PHYSICIAN(S)" referred to by NSI will result in inappropriate treatment.

AUTHORIZATIONS: Patient authorizes NSI to obtain on Patient's behalf medical laboratories, diagnostic testing, Physician(s) and dispensing pharmacies. In addition, Patient authorizes and instructs NSI and the Physician(s) referred by NSI and dispensing pharmacies obtained on my behalf to provide medical care and prescribed pharmaceuticals based on the Medical History Form, laboratory diagnostic tests, and other information submitted to NSI under this Agreement. Patient agrees to submit a photo identification for any blood testing pursuant to a NSI or Physician(s) test requisition. Patient acknowledges, understands and agrees that laboratory, diagnostic testing services supplied or obtained by NSI, and medical services provided to the Patient by Physician(s), are not covered or reimbursed by Medicare or other insurance.

PHYSICIAN(s): Patient acknowledges, understands and agrees that NSI's employees and agents are not licensed Physician(s). The Physician(s) obtained the Patient's behalf by NSI are independent contractors, compensated by Patient with funds provided to NSI. Patient acknowledges, understands, and agrees that NSI does not practice medicine. NSI is a medical management, administration and referral service and does not direct, control or influence the medical treatment decisions made by Physician(s).

MEDICAL CARE SERVICES: Patient further acknowledges, understands and agrees that NSI and Physician(s) are rendering the medical care, services and treatment and that NSI is instructed and authorized to arrange for the prescribed pharmaceuticals to be dispensed and sent to the Patient by any pharmacy in the State or County of the Patient's residence. Your prescriptions can be filled at the pharmacy of your choice. If you choose to fill your prescription(s) at Palm Beach Pharmaceuticals, Inc., and have any questions regarding your medications, please feel free to contact our pharmacist at (800) 511-1341, toll-free. Our hours are 9 AM to 5 PM Monday through Friday, 8 AM to 12 PM on Saturday.

INSTRUCTIONS AND TREATMENT: Patient acknowledges, understands and agrees to comply with the method of instructions, treatment and dosage schedules prescribed by Physician(s), to immediately cease any medical treatment prescribed by Physician(s) in the event of any adverse reaction or side effect arising from prescribed treatment, and to immediately provide NSI and Physician(s) with written notice via facsimile to 561-354-2766 of any such adverse reaction or side affect. Patient acknowledges, understands and agrees that diagnosis and treatment may involve certain risks, including injury.

HORMONE REPLACEMENT THERAPY: Patient acknowledges, understands, and agrees that the hormone blood level objective sought as a result of Patient's hormone replacement therapy, as prescribed by Physician(s), 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 of alternative methods of treatment and the possible consequences and/or complications involved in such hormone replacement treatment. Patient acknowledges, understands and agrees that recombinant human growth hormone replacement therapy involves the use of a medical drug approved for one purpose and are being used for 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(s) to administer such treatment to relieve body ailments and attempt to enhance Patient's physical condition and health. Patient further acknowledges, understands and agrees that the methods of medical treatment offered by NSI and Physician(s) are not accompanied by any claims, guarantees, promises or warranties.

MEDICAL CONSULTATION: Patient is freely seeking medical consultation via the Internet and acknowledges, understands and consents to NSI Physician(s) reviewing Patient's medical history without having the opportunity to conduct an in-person physical examination. Patient solicits NSI for a specific prescription medication to treat an already diagnosed medical or cosmetic condition. Patient acknowledges, understands that Physician(s) may not be licensed to practice medicine in Patient's state or country of residence. Further, Patient agrees that Physician(s)'s consultations, diagnoses, and treatments will be deemed to have occurred in Florida.

PRIMARY-CARE PHYSICIAN: Patient represents that he or she is under the care of a primary-care Physician and that Patient will not rely or substitute the advice of the NSI Physician(s) should it conflict with the advice given to Patient by Patient's primary-care physician. Before taking any medication prescribed by Physician(s), 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.

▸ MEDICAL MALPRACTICE INSURANCE: Patient acknowledges, understands and agrees that under Florida law, Physician(s) are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. PHYSICIAN(S) HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured Physician(s) who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

▸ PROPRIETARY BUSINESS INFORMATION: During Patient's relationship with NSI and Physician(s), NSI and Physician(s) will convey to Patient a range of proprietary business information, including, confidential disclosures and trade secrets' business practices and NSI's customers and suppliers ("Confidential Information"). No matter how received by Patient during the parties' relationship. Patient acknowledges, understands and agrees that this Information is confidential, proprietary and uniquely valuable to NSI and gravely affects the conduct of business of NSI and NSI's goodwill. Patient acknowledges, understands and 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 acknowledges, understands and agrees that if the terms of this paragraph are breached, NSI 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 in the amount of Ten Million Dollars ($10,000,000.00). Patient acknowledges, understands and agrees that the amount of NSI'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.

▸ JURISDICTION: 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 the State of Florida, 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.

▸ WAIVER: Patient acknowledges, understands and agrees that NSI is not responsible for the negligent or intentional acts or omissions of any health-care provider or supplier to whom the Patient is referred. The total liability of NSI, its officers, directors, employees, agents and stockholders for negligence or intentional acts is limited to the purchase price of any products through NSI, Physician(s) or pharmacies, and that NSI and Physician(s) will not be liable for any direct, indirect, special, incidental, consequential, or punitive damages. Patient acknowledges, understands and agrees this is a waiver of any and all liability(ies).

▸ INDEMNIFICATION: Patient covenants and agrees to indemnify, defend, protect and hold harmless NSI and Physician(s) 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, NSI 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 NSI or Physician(s), harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by NSI or Physician(s). Patient is aware of the 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.

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 has read, understands and agrees to the terms and conditions disclosed herein, including, but not limited to the waiver and indemnification clauses for any liability(ies) arising out of hormone treatment(s) rendered by NSI and Physician(s).

WITNESS(ES)	PATIENT NAME
______________________________	______________________________ (Patient: Print name)
______________________________	______________________________ (Patient's signature)
	Date signed____________________

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Nationwide Synergy, Inc. | 307 Tequesta Drive | Tequesta, FL 33469 | (561) 427-0400