Patient Medical History Form

SECTION 1: PERSONAL INFORMATION

- First Name:
- Last Name:
- Email:
- SSN:

ADDRESS

- Addr1:
- City:
- State:
- Zip:
- Country:

PHONE NUMBERS

- Home:
- Work:
- Cell:
- Fax:
- Occupation:

SECTION 2: CONFIDENTIAL MEDICAL HISTORY

- Date of Birth:
- Gender:
- Height:
- Weight:

PRIMARY PHYSICIAN INFORMATION

- Physician Name:
- Phone:
- Date of your last physical examination with your physician?

LIFESTYLE INFORMATION

- *Surgeries, Hospitalizations, Diseases, Conditions, or Other Information:*
- *Medications:*
  - (Specify Name, Dosage, etc.) or specify "none."
- *Allergies to Medication:*
  - (Specify) or specify "none."
- *Do You Smoke?* YES NO
  - If Yes, how much per day?
- *Do You Drink Alcohol?* YES NO
  - If Yes, how much per week?
- *Are You Taking Over-the-Counter Supplements?* YES NO
  - If Yes, list Name and Quantity per day/week.
- *Do You Exercise Regularly?* YES NO
  - If Yes, describe.

Diagnosed History of Disease:

- Check any current or past diseases and explain if applicable.
- Do YOU currently have or ever had any of the following? If yes, please explain below:
- If yes, please explain:
- Heart Failure

- Heart Attack
- Erectile Dysfunction
- Liver Disease
- Back Problems
- Injury
- Renal Disease
- Diabetes
- Asthma
- COPD
- Hypertension
- Orthopedic/muscle disorder/fracture/joint disorder
- Cancer
- Allergies to Medications
- Cholesterol Problems
- Fibromialgia
- Anemia
- Anxiety
- Thyroids Problems

Questions for Treatment:

- *Prospective Patients:* Check symptoms you hope to improve through hormone replacement therapy.
- *Existing Patients:* Check symptoms you have improved and hope to continue improving through HRT
- Ultimate Prime and its physicians DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT.

- Check any current or past symptoms and explain in the provided space.

- Decreased desire and ability to exercise
- Depression
- Decreased energy or endurance
- Difficulty sleeping

- Decreased sense of well-being
- Hot flashes
- Decreasing memory
- Increasing fat deposits about abdomen and/or thighs
- Cold or heat intolerance
- Muscle loss
- Increasingly stressed
- Thinning or loss of hair
- Loss of interest in sex/low Libido
- Headaches/ Migraines
- Decreasing muscle strength
- Weight loss
- Unexplained Loss of concentration, sociability
- Activity Currently Pregnant?

FAMILY HISTORY

- Check if immediate family members currently have or ever had specific conditions.

- Heart Disease Cholesterol Problems
- Diabetes Cancer
- Thyroid Problems Osteoporosis
- High Blood Pressure Anemia

  Explain any Yes answers regarding the above conditions an IMMEDIATE FAMILY MEMBER has or had.

SECTION 2b: FOR WOMEN ONLY! SYMPTOMS/PAST DIAGNOSIS:

- Check all that apply.
- SECTION 2b. FOR WOMEN ONLY!
- SYMPTOMS/PAST DIAGNOSIS: Please check all that apply

- Fibromyalgia Hot Flashes Mood Swings
- Migraines Night Sweats Breast Tenderness
- Ovarian Cysts Vaginal Dryness Water Retention
- Osteoporosis/Osteopenia Dry Skin Sleep Disorders
- Uterine Fibroids Dry Hair
- Have you ever had a Hysterectomy? YES NO ▪ If yes, Date: ▪ Type: Partial Full
- Reason:
- If no, give date of last menstruation period: ▪ Has it changed from its normal cycle? YES NO
- If yes, how has it changed? (Ex. Heavier, lighter, longer, shorter)
- Tubal ligation? YES NO ▪ If yes, Date:
- Please list any prescription hormone medications you have taken, when, and for how long you took them:
- Please list any family members that have a history of breast, uterine, ovarian or cervical cancer:
- Please provide date and details about any abnormal mammograms you may have had:
- Please provide date and details about any abnormal Pap Smear tests you may have had.
- How many times have you given birth?
- How many miscarriages, if any?
- Are you currently pregnant? YES NO
- Is there anything we didn't ask that you would like us to know?

SECTION 3: SIGNATURE

PATIENT'S AGREEMENT AND RELEASE

SECTION 3. SIGNATURE PATIENT'S AGREEMENT AND RELEASE THIS AGREEMENT is made and executed on ____________________, between Ultimate Prime LLC. (hereinafter referred to as "Ultimate Prime") and____ _______________________ (hereinafter referred to as "Patient"). IN CONSIDERATION of the Ultimate Prime, LLC., 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 Ultimate Prime or to the "PHYSICIAN(S)" referred to by Ultimate Prime will result in inappropriate treatment. AUTHORIZATIONS: Patient authorizes Ultimate Prime to obtain on Patient's behalf medical laboratories, diagnostic testing, Physician(s) and dispensing pharmacies. In addition, Patient authorizes and instructs Ultimate Prime and the Physician(s) referred by Ultimate Prime 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 Ultimate Prime under this Agreement. Patient agrees to submit a photo identification for any blood testing pursuant to a Ultimate Prime or Physician(s) test requisition. Patient acknowledges, understands and agrees that laboratory, diagnostic testing services supplied or obtained by Ultimate Prime, 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 Ultimate Prime is a medical management, administration and referral service and does not direct, control or influence the medical treatment decisions made by Physician(s). Patient acknowledges, understands and agrees that Ultimate Prime Advisors are not licensed Physician(s). Patient acknowledges, understands and agrees that Ultimate Prime Physician(s) may not be licensed to practice medicine in Patient's state or country of residence. MEDICAL CARE SERVICES: Patient further acknowledges, understands and agrees that Ultimate Prime and Physician(s) are rendering the medical care, services and treatment and that Ultimate Prime 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. 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 Ultimate Prime and Physician(s) with written notice via email to info@ultimatehrt.com of any such adverse reaction or side effect. Patient acknowledges, understands and agrees that diagnosis and treatment may involve certain risks, including injury. IF THIS IS A MEDICAL EMERGENCY – CALL 911 IMMEDIATELY! 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 Ultimate Prime and Physician(s) are not accompanied by any claims, guarantees, promises or warranties. 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 Ultimate Prime 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 non insured 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 Ultimate Prime and Physician(s), Ultimate Prime and Physician(s) will convey to Patient a range of proprietary business information, including, confidential disclosures and trade secrets' business practices and Ultimate Prime's customers and suppliers ("Confidential Information"). No matter how received by Patient during the parties' relationship. Patient acknowledges, understands and agrees that this Ultimate Prime Information is confidential, proprietary and uniquely valuable to Ultimate Prime and gravely affects the conduct of business of Ultimate Prime and Ultimate Prime'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, Ultimate Prime 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 Ultimate Prime'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 Ultimate Prime is not responsible for the negligent or intentional acts or omissions of any healthcare provider or supplier to whom the Patient is

referred. The total liability of Ultimate Prime, its officers, directors, employees, agents and stockholders for negligence or intentional acts is limited to the purchase price of any products through Ultimate Prime, Physician(s) or pharmacies, and that Ultimate Prime 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 Ultimate Prime 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, Ultimate Prime 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 Ultimate Prime or Physician(s), harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Ultimate Prime 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 indemnity Ultimate Prime and Physician(s) DATE SIGNED SIGNATURE

DATE SIGNED:

SIGNATURE: