Medical History Form

* Required Fields

Optimize U
Testosterone Optimization
Whole Body Cryo Therapy

SECTION 1: Personal Information

* First Name:
Middle Name:
* Last Name:
* Email Address:
* Social Security #:

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:

Have you already contacted Optimize U?

SECTION 2: Medical History

GENERAL

* Date of Birth:
* Gender ◯ Male ◯ Female
* Weight:
* 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
* 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

Explain Family Health History:

LIFESTYLE INFORMATION

* Do you smoke? ◯ Yes ◯ No

Do you have any allergies?

* 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 regulary? ◯ 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
* Use of medications (if yes, list medications below): ◯ Yes ◯ No
* Blood Disorders: ◯ Yes ◯ No
* Immune Disorders: ◯ Yes ◯ No
* Cancer: ◯ Yes ◯ No
* Chemical Dependency: ◯ Yes ◯ No
* Carpal Tunnel Syndrome: ◯ Yes ◯ No
* Lung Disorder: ◯ Yes ◯ No
* Orthopedic or Muscle Disorder including fracture or joint disorders: ◯ Yes ◯ No
* Heart Disease including Atherosclerosis, Angina, Heart Failure, Heart Attack: ◯ Yes ◯ No
* Allergies to Medications: ◯ Yes ◯ No
* Upper Respiratory: ◯ Yes ◯ No
* Edema/excess fluid retention: ◯ Yes ◯ No
* Poor wound healing: ◯ Yes ◯ No
* Emotional Disorders/Despression: ◯ Yes ◯ No
* Renal Disease: ◯ Yes ◯ No
* Genital - Urinary Disorder: ◯ Yes ◯ No
* Hyperlipidemia: ◯ Yes ◯ No
* Hypertension: ◯ Yes ◯ No
* Neurological Disorders: ◯ Yes ◯ No
* Thyroid, Diabetes or other endocrine disorder including insulin resistance ◯ Yes ◯ No
* Arthritis: ◯ Yes ◯ No
* Bursitis: ◯ 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, ets.) **or specify "none":**

DIAGNOSED HISTORY OF DISEASE

* Prior history of Steroids or hormones? ◯ Yes ◯ No

If yes, please select:
Male/Female

Test: ◯ Yes ◯ No

Deca: ◯ Yes ◯ No

Winstrol: ◯ Yes ◯ No

hGH: ◯ Yes ◯ No

Thyroid: ◯ Yes ◯ No

Other: ◯ Yes ◯ No

Type/Dose/Frequency:

Type/Dose/Frequency:

Prior Medical Records/Labs? ◯ Yes ◯ No

Any side effects?

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.

REVIVE INDUSTRIES, REVIVE MANAGEMENT, Optimize U Holding, Revive Cape, Revive Lexington, OU central or OU San Diego AND ITS PHYSICIANS DO NOT TREAT PATIENTS FOR ATHLETIC PERFORMANCE OR ENHANCEMENT. 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
* Increasing fat deposits around the abdomen and/or thighs ◯ Yes ◯ No
* Increasing mood swings ◯ Yes ◯ No
* Increasing sagging muscles or breats: ◯ Yes ◯ No
* Increasing wrinkles: ◯ Yes ◯ No
* Increasing stress: ◯ Yes ◯ No
* Currently Pregnant: ◯ Yes ◯ No
* Depression: ◯ Yes ◯ No
* Difficulty sleeping: ◯ Yes ◯ No
* Headaches/Migraines: ◯ Yes ◯ No
* Hot flashes: ◯ Yes ◯ No
* Loss of concentraion, sociability, activity: ◯ Yes ◯ No
* Loss of interest in sex: ◯ Yes ◯ No

* Decreased desire and ability to exxercise:	◯ 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, joint 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 Optimize U ("revive industries or revive management") 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 staff of Optimize U ("Physicians") could result in inappropriate treatment. Patient authorizes Optimize U 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 Optimize U, Physicians 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 Optimize U under this Agreement. Patient agrees to present photo identification upon receiving any blood testing pursuant to a Optimize U or Physician test requisition. Patient acknowledges that therapies and laboratory and diagnostic testing services supplied or obtained by Optimize U, and medical services provided to me by Physicians, may not be covered or reimbursed by Medicare or any other insurance.

Patient specifically swears and acknowledges that he or she is not using Optimize Us Therapy for a professional or amateur athlete or bodybuilder. Patient specifically swears and acknowledges that he or she is not seeking treatment or prescription medication by Optimize U and/or Physician for the purpose of athletic or performance or cosmetic enhancement. It is outside the scope of Optimize U and the Physician to provide these services or prescriptions under those circumstances. Hormone Therapeutics and the Physician 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.

Patient acknowledges that some of Optimize U's employees and clinical advisers are not licensed physicians. I further understand and agree that Optimize U is rendering the medical care, services and treatment, and that Optimize U 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 Optimize U with written notice of any such adverse reaction or side effect. I further acknowledge and agree that Optimize U 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 Optimize U has 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 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 to administer such treatment to relieve body ailments and deficiencies. Patient further acknowledges that the methods of medical treatment offered by Optimize U are not accompanied by claims, guarantees, promises or warranties. In compliance with federal and state laws, there will be no refund given for any medication.

Patient is freely seeking medical consultation via the internet or in person and acknowledges and consents to Physician reviewing Patient's medical history without the opportunity to conduct an in-person physical examination. Patient has contacted Optimize U for a specific prescription medication to treat an already-identified medical condition.

Patient represents that he or she is under the care of a primary care physician and the Physician, and he or she will not rely or substitute the advice of Physician should it conflict with the advice given by Patient's primary care physician. Before qualifying for any treatment or any medication prescribed by Physician, Patient agrees to have a comprehensive physical examination and to submit same to become a part of patient's records to be maintained by Optimize U. 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 Kentucky and Tennessee, applicable to agreements made and to be performed entirely within such State, without regard to principles of conflict of laws.

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 severable.

Patient covenants and agrees to indemnify, defend, protect and hold harmless Optimize U 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, Optimize U's 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 Optimize U, harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Optimize U. 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 by Optimize U staff. 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 outweighs 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 Optimize U, the entire Staff at Optimize U and the prescribing Physician 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 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 Optimize U and discontinue use until advised to resume usage by Optimize U. ☐

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

* I understand that Optimize U does not cooperate with any insurance companies. I will not request that it be processed through my insurance. ☐

* 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 en hancement or cosmetic enhancement of any kind. ☐

* 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: _____

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PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT FORM

I have received and/or reviewed the privacy practice notice (all 4 pages) for Optimize U and understand the circumstances in which Optimize U may need to utilize or release your medical records. I also understand that I agreed to the use of those Records when I initially applied for care whenever that may have occurred.

I understand that Optimize U will properly maintain your records and will use all due means to protect your privacy as outlined in this privacy practices statement.

* Patient Signature: _____ * Date: _____

* Print Patient Name: _____

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I agree, while a patient of Optimize U, I will not take any type of anabolic steroids, testosterone gels, hormone “boosters”, pro-hormones or any additional testosterone supplementation not provided by Optimize U during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Optimize U.

* Patient Sign Name: * Date:

* Please Print Name: * Date:

Optimize U

Testosterone Optimization
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I have received proper education on how to self-administer injections in my home and have also received an educational patient guide to properly administer medications requiring self-injection. Due to this education, I know feel comfortable giving my own injections.

* Patient Signature:

* Date:

Optimize U

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TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient) _____ , agree to participate in a telemedicine evaluation and/or ongoing treatment performed by an independently contracted provider who assumes sole responsibility and liability for treatment.

By signing this agreement, I authorize the electronic transmission of medical information (may include phone, text, email…) and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. (Note: the likelihood of this transmission being intercepted by persons other than those at the consulting site are extremely small). I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. I understand that Medical records of telemedicine services will be kept at Optimize U. I understand that some or all my medical information may be used for teaching or educational purposes. I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers.

* Patient Signature: _____ * Date: _____

* Print Patient Name: _____

Patient Compliance, Continuity of Treatment, and Medication Refills

1. Once established on therapy the Patient must be compliant with provider recommendations as per the initial intake paperwork (see Section 3 “Authorization and Agreement”).

2. Regarding continuity of therapy, Patient must be available for subsequent follow-up encounters to obtain laboratory samples as well as review (typically including but not limited to) laboratory results, physical examinations, symptom discussions, therapeutic recommendations, KASPER review, and medication refill authorization.

3. Staff members will attempt to contact/encounter patient a minimum of four (4) times before deeming the patient “non-compliant”. The attempted contact(s) will be documented in the Patient’s chart and must include date and time of attempt and initials of staff member. The attempt(s) will occur on 4 separate “work days” which includes business hours of 0900-1800, Monday through Friday. Certainly contact can occur outside these parameters but the decision to presume and document non-compliance shall not include failed contact on weekends or non-standard “business hours”.

4. Once Patient is determined “non-compliant” no further refill of medications will be authorized or provided. At that time OPTIMIZE U reserves the right to consider, and proceed with, terminating the Patient from the practice which also implies termination/cessation of services. Ensuring compliance and mutual understanding between the Patient and OPTIMIZE U must be documented before re-establishing therapy.

* Patient Signature: