

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation)	<input type="checkbox"/> Regular vigorous exercise			
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Number of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	Number of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Safety	Do you live alone?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have frequent falls?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have vision or hearing loss?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel depressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you panic when stressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have problems with eating or your appetite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you cry frequently?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever attempted suicide?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have trouble sleeping?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been to a counselor?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

WOMEN ONLY

Age at onset of menstruation:	
Date of last menstruation:	
Period every ____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last pap and rectal exam?	

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, # of times ____				
Do you feel pain or burning with urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel burning discharge from penis?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has the force of your urination decreased?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any difficulty with erection or ejaculation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:	<input type="checkbox"/> Circulation
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight	<input type="checkbox"/> Lungs
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level	<input type="checkbox"/> Bowel
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep	<input type="checkbox"/> Other pain/discomfort

Treatment Questionnaire (Answer All That Apply)

Decreased concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased sociability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased mood swings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased short term memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased stress levels	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased long term memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased personal drive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased sense of well being	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feeling less confident	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulties sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased sex drive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased energy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased endurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Healing from exercise is long	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased muscle strength	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased testicle size	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased skin elasticity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased skin tone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased libido	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased fat deposits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased wrinkles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased muscle deterioration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gynocomastia (male breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nipple sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hot flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heavy menstrual cycle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful menstrual cycle	<input type="checkbox"/> Yes <input type="checkbox"/> No
Temperature intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral birth control or estrogen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thinning or loss of hair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thinning pubic hair	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sagging or loose skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thin / dry skin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stiff joints in morning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased bone mass	<input type="checkbox"/> Yes <input type="checkbox"/> No
Progressive osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches and pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain during exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you experienced problems with your joints? If "Yes" explain	
Have you experienced muscle aches and pains? If "Yes" explain	
Have you ever been on Hormone Therapy? If "Yes" explain	
Have you ever been on a testosterone program? If "Yes" explain	
Have you ever been on a HGH program? If "Yes" explain	

I the patient, agree to submit this Medical History as accurately, truthfully, and completely. I the patient also agree that failure to provide truthful, accurate and complete information on this Medical History or to Spectrum Services LLC or physicians referred by Spectrum Services LLC could result in inappropriate treatment. I the patient also understand that this record submitted will be held in the highest confidentiality as set by the Health Information Act. And other established Law and will to only be used to further my medical treatment.

Patient Printed Name: _____ Patient Signature: _____



HEALTH INFORMATION AUTHORIZATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information without your authorization.

I hereby authorize Spectrum Services or any of its employees to use or disclose my Patient Health information to the following person(s), entity(ies), or business associated of this office:
Spectrum Services, LLC

Patient Health information authorized to be disclosed:

Lab work, medical history, physical examinations, diagnoses on therapies, telemedicine encounters, and tele-health encounters

For the specific purpose of:

Bio-identical hormone therapy, Andropause Treatment, Menopause Treatment, and Hormone Deficiency Treatment.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Spectrum Services and that revocation will not affect Spectrum Services previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Patient Signature: _____

Date: _____



Therapy Management Agreement

This agreement between _____(patient) and Spectrum Services establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. Spectrum Services and (patient) agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

The patient agrees and accepts to the following conditions:

- A. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
- B. I will immediately report any adverse side effect related to the use of my medication my Spectrum assigned physician and discontinue use until advised to resume usage by a Spectrum Services physician.
- C. I will safeguard my medications from loss or theft.
- D. I will not share, sell, or trade my medications for money, goods, or services.
- E. I agree that I will use my medication at the prescribed rate and dosage and will keep the medication in its respective labeled container.
- F. I will not attempt to obtain "scheduled" hormone therapy medications illegally or from any other health care practitioner without disclosing my current medication usage. I understand that it is against the law to do so.

Spectrum Services only treats patients over the age of 30 with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency) established through a complete health assessment conducted by a Spectrum network physician in your state through the use of a physical examination, complete diagnostic blood test, completed medical history, and physician evaluation.

These statements have not been evaluated by the FDA. No prescription will be provided unless a clinical need exists based on required lab work, physician consultation, and current medical history either through patients' personal physician or Spectrum Services network physician. Please note, agreeing to lab work does not automatically qualify patient to clinical necessity and prescription.

I have read and agree to the terms of the Therapy Management Agreement.

Patient Signature: _____

Printed Name: _____

Date: _____



Disclosure

Thank you for working with Spectrum Services, a healthcare network specializing in Age Management and Bio-Identical Hormone Therapy. Clients seek our physician monitored medical treatments to improve overall health and well-being. An important part of that treatment often includes Bio-Identical Hormone Therapy under strict guidelines and watchful management by skilled licensed health care professionals. Our goal is to provide sound, responsible, ethical and proper treatment for Adult Hormone Deficiency.

Before our physicians can provide any therapy they require the following:

- A. Acceptable, updated blood work
- B. Verification of access to a primary care physician with whom you have had recent [within 12 months] physical examination (copy of the physical required)
- C. A scheduled office visit to a Spectrum Services network physician and/or telemedicine encounter with a Spectrum Services network physician.
- D. Completion of all Spectrum Services paperwork

Often clients who are referred to us have received medications from other Physicians or HRT companies who may or may not follow the same medical evaluations or treatment protocols as we do. In some cases where inappropriate medications, dosages, and protocols were provided, some clients' health may have been jeopardized. Spectrum Services and their staff not excluding Medical Directors, Physicians and Physician Extenders take no responsibility or liability for a clients' participation in any prior HRT program. Our physician therapies are customized and based on strict medical guidelines. We do not use or condone the use of performance enhancement protocols or cyclical hormone therapies. By signing this disclosure you are holding Spectrum Services and their medical staff harmless for health issues that are present, or may arise in the future from previous therapies, medications or protocols.

I have read, understand and agree to the statements and disclosures in this document

Print Name: _____

Sign Name: _____

Date: _____



Medical Records Release

I, _____ give my permission to release my medical records to:
(please print)

Spectrum Services
8004 NW 154 St #106
Miami Lakes, FL 33016
Fax: 866.572.1427

From: Doctor: _____

Address: _____

Phone Number: _____

Patient Date of Birth: ____/____/____

Patient Signature: _____