New Patient Evaluation Form for Men (9/1/2009)

Please fax completed forms to 1-888-370-4670 or scan and email to medical@oh-labs.com.
For assistance, call 1-877-216-8004, option 1. **Include leading "1" when sending by fax**.

Personal Information

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

Name (first, MI, last)	Date of Birth (mm-dd-yyyy)	Social Security Number
>	> - -	> - -

Home Address (**no P.O. Boxes**)	City	State	Zip
>	>	>	>

Shipping Address (**no P.O. Boxes - only if different from above**)	City	State	Zip
>	>	>	>

Phone 1 ☐ Mobile ☐ Home ☐ Work	Phone 2 ☐ Mobile ☐ Home ☐ Work	Email
>	>	>

Payment Information

Credit Card Number ☐ Visa ☐ MC ☐ Disc ☐ Amex	Visa, MC, Disc - Card Verification Code from back of card
> - - -	>

Name as it appears on credit card	Expiration (mm-yy)	Amex - Unique Card Code from front of card
>	> -	>

Insurance Information (YOU MUST ATTACH A COPY OF INSURANCE CARD, FRONT & BACK)

Medicare Number	Medicaid Number	State	Relationship to Insured
> (we do not accept Medicare at this time)	> (we do not accept Medicaid at this time)	>	☐ Self ☐ Spouse ☐ Depend.

Name of Primary Insurance Company	Member/Insured ID Number	Group Number
>	>	>

Address of Primary Insurance Company	City	State	Zip
>	>	>	>

Employer Name/Employer Number	Insured's Social Security Number (if not patient)
>	> - -

Credit Card Authorization (please sign and date below)

I acknowledge that I have selected credit card billing by providing my credit card information and hereby authorize Optimal Health Laboratories or its partners and affiliates to bill my credit card. I hereby assign and authorize payment directly to Optimal Health Laboratories or its partners and affiliates for the Optimal Health Evaluation in the amount of $_______.

I acknowledge that I may or may not be medically eligible as a result of my lab tests and Optimal Health Evaluation for continued services and products from Optimal Health Laboratories or its partners and affiliates. Further, I acknowledge that even if I am medically eligible as a result of my lab tests and Optimal Health Evaluation for continued services and products from Optimal Health Laboratories or its partners and affiliates, my health care provider and/or I may for any reason decide not to receive continued services and products from Optimal Health Laboratories or its partners and affiliates. I acknowledge that if my health care provider and I decide to receive continued services and products from Optimal Health Laboratories or its partners and affiliates that I must authorize my health care provider to submit a prescription to Optimal Health Laboratories or its partners and affiliates for said services and products. I acknowledge that if I authorize my health care provider to submit a prescription to Optimal Health Laboratories or its partners and affiliates for continued services and products, I hereby assign and authorize payment directly to Optimal Health Laboratories or its partners and affiliates for the Optimal Health Program (due to the nature of compounded pharmaceuticals and individual patient requirements, your physician will discuss pricing with you prior to submitting your prescription).

Signature: ______________________________ Date: ______________________

Insurance Authorization (please sign and date below)

I acknowledge that I have selected insurance billing by providing my insurance information and hereby authorize Optimal Health Laboratories or its partners and affiliates to bill my insurance carrier. Further, I authorize Optimal Health Laboratories or its partners and affiliates to disclose to my insurance carrier the information on this form and any accompanying documentation provided by my health care provider. I authorize my health plan or insurance carrier, and other third-parties involved in the administration of my plan, to disclose to Optimal Health Laboratories or its partners and affiliates information concerning my plan, including benefits, coverage limitations, and payments made for services. I hereby assign and authorize payment directly to Optimal Health Laboratories or its partners and affiliates of any benefits for the services provided.

Signature: ______________________________ Date: ______________________

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Waiver of Claims and Informed Consent Agreement

Please sign and date below

Optimal Health Laboratories (hereafter "Optimal Health" or "OHL") and the individual who purchases a medical treatment from OHL (hereafter the "Patient") enter into this Patient Waiver of Claims and Informed Consent Agreement (hereafter "Agreement") in consideration of the promises contained herein and other agreed adequate consideration. The Parties understand, accept and agree to all the terms, conditions and provisions of this Agreement on the date written below.

I, the undersigned Patient, accept, understand, and agree to the following terms, provisions and conditions:

Optimal Health Laboratories. Patient understands that OHL is a medical services administration company managing and coordinating medical services, physician services, laboratory services, pharmacy services, other services, prescription drugs and products provided to Patient by independent contractors, physicians, medical organizations, diagnostic medical laboratories, pharmacies and other individuals or entities on behalf of OHL.

Independent Contractors of OHL. Independent contractors and medical organizations that may provide medical services, physician services, laboratory services, pharmacy services, other services, prescription drugs and products to Patient on behalf of OHL include, but are not limited to the following: a) physicians and medical organizations that conduct Patient's physical examination, evaluate Patient's physical exam results, medical history, medical complaint, and prescribe medication or medical treatment to Patient; b) diagnostic medical testing laboratories; and c) pharmacies that dispense prescribed medication directly to Patient.

Medical Service and Products Provided: Physical Examination, Prescribing or Treatment, Dispensing Pharmacy and Supervision of Patient Medical Treatment. The physician conducting the physical examination of Patient, or other physician within the medical organization employing the examining physician if the examining physician is not available (hereafter the "Physician"), shall be responsible for supervising medical treatments prescribed to Patient. Patient agrees to undergo a medical laboratory urine or blood test if required for the OHL treatment program purchased. Physician shall evaluate the physical exam report, medical history report, any laboratory test report and the medical complaint of Patient in determining whether or not to issue a prescription for a medical treatment requested by Patient.

Physician Conducts a Physical Examination and Evaluates Patient's Medical History and Medical Complaint Before Prescribing any Medical Treatment. Patient understands that OHL does not anticipate any adverse effect to arise as a result of any medical program provided to Patient. Patient also understands that the practice of medicine is not an exact science and that no specific outcome from treatment can be assured to Patient.

Patient is freely seeking medical services offered by OHL with an understanding that the Physician will conduct the physical examination of Patient and supervise Patient's medical treatment. Patient is also aware that all medical programs offered by OHL require that the Physician prescribe any medical program offered by OHL. Patient has examined and requested a medical program offered by OHL and understands the nature and risks inherent in the medical program purchased from OHL. Patient represents that all information provided to Physician and OHL by Patient is complete, correct and accurately reflects Patient's known medical condition.

Patient Agrees to Provide Accurate and Complete Information to Physician and OHL. Physician shall obtain Patient information, draw conclusions and make decisions based upon Patient's honest responses to questions presented to Patient. Patient represents that all responses to questions regarding Patient's medical condition shall be truthful, accurate and complete. Patient understands that failure to provide truthful, accurate and complete information to Physician or OHL on any data collection form could cause Physician to unknowingly make an inappropriate treatment decision affecting the physical or mental health of Patient.

Physician is an Independent Contractor of OHL. Patient understands that OHL does not practice medicine and functions as a medical administration organization coordinating the services and products of medical organizations. Unless otherwise communicated by OHL to Patient in writing, the Physician is an independent contractor of OHL and is not an agent or employee of OHL. OHL does not direct, control or influence the treatment decisions made by Physician with respect to Patient care or any Patient request for specified treatment. OHL compensates Physician the same amount for professional services rendered regardless of whether or not a prescription is issued for treatment sought by Patient.

Patient understands and agrees that Patient medical records become the property of OHL; and that, in addition, OHL will have continuing access to and the right to copy and retain any and all portions of Patient medical records. Patient understands and agrees that a duplicate copy of Patient medical records become the property of the medical organization or physician that conducts Patient's physical examination; and that, in addition, said medical organization and examining physician shall have continuing access to and the right to copy and retain any and all portions of Patient's medical records.

Miscellaneous Provisions. (a) Patient understands that prescription medications cannot be returned to the dispensing pharmacy, OHL or any other individual or entity after the medication has been dispensed to Patient. (b) This Agreement represents the complete and entire agreement between the parties to it. No prior written or electronic agreement, verbal communication or verbal agreement may be offered or used to alter any terms or condition of this Agreement; nor shall such extrinsic agreements be effective or binding between the parties regarding any term or condition of this Agreement or be offered or introduced to show intent of a party to any matter pertaining to this Agreement. (c) Patient agrees that a delivery receipt for a shipment from OHL, its contractors, any independent pharmacy, or any delivery service signed by a person at the Patient's shipping address shall constitute conclusive evidence of the delivery and receipt of the prescription drug and full performance of the obligations of OHL to Patient. Patient irrevocably agrees and instructs Visa, MasterCard, or other credit card provider or processor, and Patient's bank to withdraw any asserted credit card dispute submitted should independent evidence of delivery of the shipment to Patient's address be provided by OHL. Federal Express or other delivery services reported delivery to the Patient's shipping address on the Federal Express or delivery service's website shall constitute delivery to Patient. Federal Express's or other delivery service's reported delivery to the Patient's shipping address on the Federal Express or other delivery service's website with a reported wavier of signature on file with Federal Express or other delivery service for deliveries to Patient's shipping address shall also constitute delivery of the prescription drug and its receipt by Patient. The reported delivery of the prescription medicine shipment by the United States Postal Service to the Patient's address on its website shall also constitute delivery to Patient and conclusive evidence of the full performance of this Agreement by OHL. OHL shall use its best efforts in good faith to assure a high level of service to Patient, including the timely delivery of all prescription medicine dispensed by the responsible pharmacy.

Patient's Representations and Assurances. (a) Patient is over 18 years of age. (b) Patient agrees that any claim or action brought by Patient against OHL, its agents, officers, directors, owners, shareholders, contractors and affiliated companies shall be brought in Dallas County, Texas, which is granted exclusive jurisdiction and venue of claims brought by Patient, or any assignee, against said parties, arising from any transaction or occurrence involving Patient and said parties. Patient unconditionally and expressly waives all claims and defenses that might be brought or asserted by Patient in any such action against said parties. Patient agrees that this agreement is voluntary, and that it is binding to any individual or entity claiming by or through Patient or on behalf of Patient. Patient further agrees to pay all attorneys fees and costs incurred by OHL as they are incurred in the event Patient brings any action or claim against OHL in violation of this provision; or in violation of any term, condition or provision of this Agreement; or brings an action against OHL, or any of its officers, directors, employees, agents or contractors inconsistent with Patient's waiver of all claims and defenses as set forth in this Agreement. (c) Patient is aware of potential side effects associated with medication requested by Patient and personally accepts all risks involved in taking such medication; and Patient agrees not to seek any indemnification, damages of any kind, or any other liability from OHL, its officers, directors, employees, parent, subsidiaries, affiliates, contractors, agents, or any medical organization or pharmacy that provides Patient with medical services or products at the request of OHL in the event Patient experiences any of the adverse side effects of prescribed medication. (d) Patient understands that OHL, its employees, agents, contractors, contracting physicians, nurses, sales personnel, administrative personnel and other entities and organizations and their employees who provide medical services or products to Patient at the request of OHL cannot guarantee that the prescription medication or treatment sought by Patient will provide the results sought by Patient. (e) Patient has obtained and consulted with Patient's primary care physician and/or pharmacist and Patient is not taking any medication or combination of medications that will make the medication requested from OHL inadvisable to take (contraindicated); and Patient agrees to advise Patient's primary care physician of any medications obtained through OHL before commencing use of such medication. (f) Patient agrees that this Agreement shall serve as Patient's authorization for OHL to release or disclose Patient's medical information to medical organizations rendering medical services to Patient at the request of OHL. This consent does not give OHL the right to sell Patient's name or information to any third party.

PATIENT UNCONDITIONALLY AND EXPRESSLY WAIVES ANY AND ALL CLAIMS AND DEFENSES AGAINST OHL, ITS SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, CONTRACTING PHYSICIANS, AND ANY AND ALL ORGANIZATIONS AND THEIR EMPLOYEES PROVIDING SERVICES OR PRODUCTS TO PATIENT ON BEHALF OF OHL FOR ANY CLAIM RELATING DIRECTLY OR INDIRECTLY TO ANY SERVICE OR PRODUCT PURCHASED BY PATIENT FROM OHL. THIS WAIVER INCLUDES, BUT IS NOT LIMITED TO, ANY ILLNESS, BODILY INJURY OR OTHER ADVERSE PHYSICAL, MENTAL OR MEDICAL CONDITION SUSTAINED BY PATIENT AS A RESULT OF A SERVICE OR PRODUCT PURCHASED FROM OHL BY PATIENT OR PROVIDED TO PATIENT BY ANY MEDICAL ORGANIZATION OR CONTRACTING PHYSICIAN OF OHL. PATIENT EXPRESSLY WAIVES ANY AND ALL DEFENSES IN ANY ACTION BROUGHT BY PATIENT AGAINST OHL OR ANY OF ITS CONTRACTORS. PATIENT UNDERSTANDS THE NATURE OF THIS WAIVER OF CLAIMS AND DEFENSES AND VOLUNTARILY AGREES TO THIS WAIVER OF CLAIMS AND DEFENSES. THIS WAIVER OF CLAIMS AND DEFENSES IS BINDING TO ANY INDIVIDUAL OR ENTITY CLAIMING BY, OR THROUGH, OR ON BEHALF OF PATIENT. PATIENT HOLDS OHL, ITS AGENTS, SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES AND CONTRACTORS HARMLESS AND INDEMNIFIES EACH FOR ANY LIABILITY ARISING IN CONNECTION WITH THE TREATMENT PROGRAM PURCHASED FROM OHL BY PATIENT.

Signature: ______________________________ Date: ______________________________

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I. Personal Health History

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

To determine your present state of health, please mark **yes** or **no** as it applies to each condition or question	Yes	No
1. Headaches (migraine, cluster, tension)	☐	☐
2. Neurological disorder (epilepsy, seizure, stroke)	☐	☐
3. Lung disorders (asthma, pneumonia, bronchitis, emphysema)	☐	☐
4. Heart disease (atherosclerosis, angina, heart failure, heart attack, stroke)	☐	☐
5. Hypertension (high blood pressure)	☐	☐
6. Hyperlipidemia (high cholesterol)	☐	☐
7. Peptic ulcer / reflux esophagitis / pancreatitis	☐	☐
8. Irritable bowel disease / Crohn's disease	☐	☐
9. Liver or gall bladder disease	☐	☐
10. Edema or excess fluid retention	☐	☐
11. Insulin resistance or diabetes	☐	☐
12. Thyroid disease	☐	☐
13. Other hormonal deficiencies including growth hormone	☐	☐
14. Cancer > if yes, what type(s) of cancer, date(s), treatment type(s)	☐	☐
15. Arthritis or joint problems including herniated disc	☐	☐
16. Musculoskeletal problems including osteoporosis (describe)	☐	☐
17. Have you had any other medical problems that have been diagnosed by other health care professionals (describe)	☐	☐

Have you recently experienced any of the following, please mark **yes** or **no** as it applies to each condition

	Yes	No		Yes	No
18. Loss of concentration, sociability, activity	☐	☐	29. Brittle nails	☐	☐
19. Decreased short or long-term memory	☐	☐	30. Dry skin	☐	☐
20. Decreasing desire or ability to exercise	☐	☐	31. Hair loss	☐	☐
21. Decreasing sense of well-being	☐	☐	32. Chest pains	☐	☐
22. Loss of interest in/or desire for sex	☐	☐	33. Palpitations	☐	☐
23. Cold or heat intolerance	☐	☐	34. Swelling of ankles	☐	☐
24. Indigestion or difficulty swallowing	☐	☐	35. Easily tired	☐	☐
25. Stomach pain	☐	☐	36. Night sweating	☐	☐
26. Belching	☐	☐	37. Unusual or excess sweating	☐	☐
27. Heartburn	☐	☐	38. Difficulty breathing	☐	☐
28. Bloating after meals	☐	☐			

	Yes	No
39. Have you had any surgeries (describe) Surgery Year Reason Hospital	☐	☐
40. Have you had any other hospitalizations (describe) Hospitalization Year Reason Hospital	☐	☐
41. Have you ever had a blood transfusion	☐	☐

Continued on next page >>>

Personal Health History continued

#	Question	Yes	No
42.	Do you take any prescribed or over-the-counter drugs (describe) Drug Dose Frequency	☐	☐
43.	Are you allergic to any medications (describe) Drug Reaction	☐	☐
44.	Are you currently dieting to lose weight or for other health reasons	☐	☐
45.	If you answered yes above, are you on a diet prescribed by a health care professional	☐	☐
46.	Do you use recreational drugs	☐	☐
47.	If you answered yes above, have you ever received recreational drugs with a needle	☐	☐
48.	Do you currently use tobacco products (cigarettes, cigars, pipe, chew, etc.)	☐	☐
49.	Are you sexually active	☐	☐
50.	Do you experience any discomfort with intercourse	☐	☐

51. How many times do you eat per day, please mark below as it applies to frequency
☐ One ☐ Two ☐ Three ☐ Four ☐ Five or more

52. How many servings of fruits or vegetables do you eat per day (a serving is approx. one handful)
☐ Less than one ☐ One ☐ Two ☐ Three ☐ Four or more

53. How many glasses of water do you drink per day (one glass is approx. 8 ounces)
☐ Less than one ☐ One-Two ☐ Three-Four ☐ Five-Seven ☐ Eight or more

54. How many times per day do you eat sweet or sugary foods
☐ Less than one ☐ One ☐ Two ☐ Three ☐ Four or more

55. How many times per day do you eat salty foods
☐ Less than one ☐ One ☐ Two ☐ Three ☐ Four or more

56. How many times per day do you eat fatty or fried foods
☐ Less than one ☐ One ☐ Two ☐ Three ☐ Four or more

57. How many times per day do you consume caffeine (one cup of coffee or tea, one can of soda)
☐ Less than one ☐ One ☐ Two ☐ Three ☐ Four or more

58. How many times per week do you consume alcohol (one glass of wine, one cocktail, one beer)
☐ Less than one ☐ One-Two ☐ Three-Four ☐ Five-Six ☐ Seven or more

59. How much do you exercise, please mark below at it applies to frequency

☐ Never	☐ Rarely	☐ Occasionally	☐ Regularly
i.e. no exercise or physical activity	i.e. climb stairs, walk 3 blocks, golf	i.e. less than 4x/week for 30 mins.	i.e. 4x/week for 30 mins. or more

II. Family Health History

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

The criteria in this section apply to your family's health history, please mark your answers where appropriate

#		Living	Deceased	Age	Significant Health Problem or Cause of Death
1.	Father	☐	☐	______	______
2.	Mother	☐	☐	______	______
3.	Brother ☐ Sister ☐	☐	☐	______	______
4.	Brother ☐ Sister ☐	☐	☐	______	______
5.	Brother ☐ Sister ☐	☐	☐	______	______
6.	Brother ☐ Sister ☐	☐	☐	______	______
7.	Brother ☐ Sister ☐	☐	☐	______	______
8.	Brother ☐ Sister ☐	☐	☐	______	______

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Family Health History continued

		Living	Deceased	Age	Significant Health Problem or Cause of Death
9.	Son ☐ Daughter ☐	☐	☐	______	______
10.	Son ☐ Daughter ☐	☐	☐	______	______
11.	Son ☐ Daughter ☐	☐	☐	______	______
12.	Son ☐ Daughter ☐	☐	☐	______	______
13.	Son ☐ Daughter ☐	☐	☐	______	______
14.	Son ☐ Daughter ☐	☐	☐	______	______

III. Mental Health

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

	The questions in this section apply to your mental health, please mark yes or no as it applies to each question	**Yes**	**No**
1.	Is stress a major problem for you	☐	☐
2.	Do you panic when stressed	☐	☐
3.	Do you have problems with your eating or your appetite as a result of stress	☐	☐
4.	Do you have trouble sitting still or concentrating as a result of stress	☐	☐
5.	Do you often have physical symptoms resulting from stress (upset stomach, pain in your back, neck or shoulders)	☐	☐
6.	Have you ever seriously thought about hurting yourself	☐	☐
7.	Do you have trouble falling asleep or staying asleep	☐	☐
8.	Do you work excessively	☐	☐
9.	Do you feel depressed	☐	☐
10.	Have you ever attempted suicide	☐	☐
11.	Do you cry frequently	☐	☐
12.	Are you easily angry or irritable	☐	☐
13.	Have you ever been to a counselor	☐	☐

IV. Other Questions

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

	The questions in this section apply to your health and vitality, please mark yes or no as it applies to each question	**Yes**	**No**
1.	Do you usually get up to urinate during the night	☐	☐
2.	If you answered yes above, do you get up more than once during the night	☐	☐
3.	Do you feel pain or burning during urination	☐	☐
4.	Do you notice or have you noticed any blood in your urine	☐	☐
5.	Has the force of your urine stream decreased	☐	☐
6.	Have you had a kidney, bladder or prostate infection within the last year	☐	☐
7.	Do you experience any problems emptying your bladder completely	☐	☐
8.	Do you experience any difficulty with erection or ejaculation	☐	☐
9.	Do you feel any testicular pain or swelling	☐	☐
10.	Have you had a prostate and/or rectal exam within the last year	☐	☐
11.	Have you noticed a loss of muscle mass or tone	☐	☐
12.	Have you noticed an increase in abdominal fat	☐	☐
13.	Do you feel more hesitant and/or less confident	☐	☐
14.	Do you feel your sexual performance has declined	☐	☐
15.	Is your hair thinning or have you noticed hair loss	☐	☐
16.	Is your skin thinning, less elastic or less supple	☐	☐
17.	Do you feel it is hard to recover from physical activity	☐	☐
18.	Do you put on weight easily	☐	☐
19.	Do you have trouble getting up in the morning	☐	☐

<STOP> PLEASE HAND COMPLETED FORMS TO YOUR HEALTH CARE PROVIDER <STOP>

<STOP> TO BE COMPLETED BY HEALTH CARE PROVIDER <STOP>

V. Medical Evaluation

(prescription form available online at www.oh-labs.com/forms.html)

Physical Assessment

Mark your selections with a ☑ Mark mistakes with a ☒ and your initials

Height	Weight	Heart Rate	Respirations	Blood Pressure	Forced Vital Capacity	Body Fat
				/		
(inches)	(pounds)	(beats/min.)	(breaths/min.)	(systolic/diastolic)	(liters)	(percent)

Subjective Assessment: if abnormal, please specify and indicate whether non-clinically significant (**NCS**) or clinically significant (**CS**)

Psychiatric
- ☐ Normal ☐ NCS ☐ Alcohol or Drug Abuse ☐ Depression ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Neurological
- ☐ Normal ☐ NCS ☐ Epilepsy ☐ Cerebrovascular Accident ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Ears/Nose/Throat
- ☐ Normal ☐ NCS ☐ If CS, specify
- ☐ Abnormal ☐ CS Notes: ____

Cardiovascular
- ☐ Normal ☐ NCS ☐ Hypertension ☐ Myocardial Infarction ☐ Angina ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Respiratory
- ☐ Normal ☐ NCS ☐ Asthma ☐ COPD ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Gastrointestinal
- ☐ Normal ☐ NCS ☐ Peptic Ulcer ☐ Bowel Disease ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Hepatic
- ☐ Normal ☐ NCS ☐ Hepatitis ☐ Hepatic Impairment ☐ Gallbladder Disease ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Genitourinary
- ☐ Normal ☐ NCS ☐ Renal Impairment ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Endocrine
- ☐ Normal ☐ NCS ☐ Diabetes ☐ Thyroid Disease ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Musculoskeletal
- ☐ Normal ☐ NCS ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Other, specify
- ☐ Abnormal ☐ CS Notes: ____

Dermatological
- ☐ Normal ☐ NCS ☐ if CS, specify
- ☐ Abnormal ☐ CS Notes: ____

Hematological
- ☐ Normal ☐ NCS ☐ if CS, specify
- ☐ Abnormal ☐ CS Notes: ____

Objective Assessment

HEENT	☐ Normal	☐ Abnormal	Notes: ____
Neck	☐ Normal	☐ Abnormal	Notes: ____
Chest	☐ Normal	☐ Abnormal	Notes: ____
COR	☐ Normal	☐ Abnormal	Notes: ____
Abdomen	☐ Normal	☐ Abnormal	Notes: ____
Extremities	☐ Normal	☐ Abnormal	Notes: ____
Neurological	☐ Normal	☐ Abnormal	Notes: ____
Rectal Exam	☐ Normal	☐ Abnormal	Notes: ____

DID YOU REMEMBER TO INCLUDE A COPY OF THE PATIENT'S REQUISITION FORM?

Your name: ____ **Date:** ____ **Last four digits of your NPI number**: ___ ___ ___ ___

Please fax forms to 1-888-370-4670 or scan and email to medical@oh-labs.com. Include leading "1" when sending by fax.