

# New Patient Evaluation Form for Women (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 <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work >		Phone 2 <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work >		Email >	

## Payment Information

Credit Card Number <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Disc <input type="checkbox"/> 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 > (we do not accept Medicare at this time)		Medicaid Number > (we do not accept Medicaid at this time)		State >	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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: \_\_\_\_\_

# 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 waiver 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: \_\_\_\_\_

**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)	<input type="checkbox"/>	<input type="checkbox"/>
2. Neurological disorder (epilepsy, seizure, stroke)	<input type="checkbox"/>	<input type="checkbox"/>
3. Lung disorders (asthma, pneumonia, bronchitis, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart disease (atherosclerosis, angina, heart failure, heart attack, stroke)	<input type="checkbox"/>	<input type="checkbox"/>
5. Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
6. Hyperlipidemia (high cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
7. Peptic ulcer / reflux esophagitis / pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
8. Irritable bowel disease / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>
9. Liver or gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
10. Edema or excess fluid retention	<input type="checkbox"/>	<input type="checkbox"/>
11. Insulin resistance or diabetes	<input type="checkbox"/>	<input type="checkbox"/>
12. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
13. Other hormonal deficiencies including growth hormone	<input type="checkbox"/>	<input type="checkbox"/>
14. Cancer > if yes, what type(s) of cancer, date(s), treatment type(s)	<input type="checkbox"/>	<input type="checkbox"/>
.....		
.....		
15. Arthritis or joint problems including herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
16. Musculoskeletal problems including osteoporosis (describe) .....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you had any other medical problems that have been diagnosed by other healthcare professionals (describe)	<input type="checkbox"/>	<input type="checkbox"/>
.....		
.....		

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	<input type="checkbox"/>	<input type="checkbox"/>	29. Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
19. Decreased short or long-term memory	<input type="checkbox"/>	<input type="checkbox"/>	30. Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
20. Decreasing desire or ability to exercise	<input type="checkbox"/>	<input type="checkbox"/>	31. Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
21. Decreasing sense of well-being	<input type="checkbox"/>	<input type="checkbox"/>	32. Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
22. Loss of interest in/or desire for sex	<input type="checkbox"/>	<input type="checkbox"/>	33. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
23. Cold or heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	34. Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
24. Indigestion or difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	35. Easily tired	<input type="checkbox"/>	<input type="checkbox"/>
25. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	36. Night sweating	<input type="checkbox"/>	<input type="checkbox"/>
26. Belching	<input type="checkbox"/>	<input type="checkbox"/>	37. Unusual or excess sweating	<input type="checkbox"/>	<input type="checkbox"/>
27. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	38. Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
28. Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>			
39. Have you had any surgeries (describe)				<input type="checkbox"/>	<input type="checkbox"/>
Surgery .....			.....		
Year .....			.....		
Reason .....			.....		
Hospital .....			.....		
.....					
.....					
.....					
40. Have you had any other hospitalizations (describe)				<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization .....			.....		
Year .....			.....		
Reason .....			.....		
Hospital .....			.....		
.....					
.....					
.....					
41. Have you ever had a blood transfusion				<input type="checkbox"/>	<input type="checkbox"/>
42. Do you take any prescribed or over-the-counter drugs (describe)				<input type="checkbox"/>	<input type="checkbox"/>
Drug .....			.....		
Dose .....			.....		
Frequency .....			.....		
.....					
.....					
.....					

**Personal Health History continued**

	Yes	No
43. Are you allergic to any medications (describe) Drug _____ Reaction _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
44. Are you currently dieting to lose weight or for other health reasons	<input type="checkbox"/>	<input type="checkbox"/>
45. If you answered yes above, are you on a diet prescribed by a health care professional	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
47. If you answered yes above, have you ever received recreational drugs with a needle	<input type="checkbox"/>	<input type="checkbox"/>
48. Do you currently use tobacco products (cigarettes, cigars, pipe, chew, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
49. Are you sexually active	<input type="checkbox"/>	<input type="checkbox"/>
50. If you answered yes above, are you trying to get pregnant	<input type="checkbox"/>	<input type="checkbox"/>
51. If you answered no above, do you use a hormonal method of birth control (birth control pill, patch, implant, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
52. Do you experience any discomfort with intercourse	<input type="checkbox"/>	<input type="checkbox"/>
53. How many times do you eat per day, please mark below as it applies to frequency <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five or more		
54. How many servings of fruits or vegetables do you eat per day (a serving is approx. one handful) <input type="checkbox"/> Less than one <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four or more		
55. How many glasses of water do you drink per day (one glass is approx. 8 ounces) <input type="checkbox"/> Less than one <input type="checkbox"/> One-Two <input type="checkbox"/> Three-Four <input type="checkbox"/> Five-Seven <input type="checkbox"/> Eight or more		
56. How many times per day do you eat sweet or sugary foods <input type="checkbox"/> Less than one <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four or more		
57. How many times per day do you eat salty foods <input type="checkbox"/> Less than one <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four or more		
58. How many times per day do you eat fatty or fried foods <input type="checkbox"/> Less than one <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four or more		
59. How many times per day do you consume caffeine (one cup of coffee or tea, one can of soda) <input type="checkbox"/> Less than one <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four or more		
60. How many times per week do you consume alcohol (one glass of wine, one cocktail, one beer) <input type="checkbox"/> Less than one <input type="checkbox"/> One-Two <input type="checkbox"/> Three-Four <input type="checkbox"/> Five-Six <input type="checkbox"/> Seven or more		
61. How much do you exercise, please mark below at it applies to frequency <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Regularly <small>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</small>		

**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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
2. Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
3. Brother <input type="checkbox"/> Sister <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
4. Brother <input type="checkbox"/> Sister <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
5. Brother <input type="checkbox"/> Sister <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6. Brother <input type="checkbox"/> Sister <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
7. Brother <input type="checkbox"/> Sister <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
8. Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
9. Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
10. Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
11. Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
12. Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

### 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	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you panic when stressed	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have problems with your eating or your appetite as a result of stress	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have trouble sitting still or concentrating as a result of stress	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you often have physical symptoms resulting from stress (upset stomach, pain in your back, neck or shoulders)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever seriously thought about hurting yourself	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have trouble falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you work excessively	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you feel depressed	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you cry frequently	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you easily angry or irritable	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been to a counselor	<input type="checkbox"/>	<input type="checkbox"/>

### 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. Have you had your period within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>
2. If you answered yes above, do you have heavy, irregular or painful discharge	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been pregnant	<input type="checkbox"/>	<input type="checkbox"/>
4. If you answered yes above, have you had any children	<input type="checkbox"/>	<input type="checkbox"/>
5. If you answered yes to question 3, have you had any miscarriages or abortions	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you pregnant or breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a D&C, hysterectomy or cesarean	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any urinary tract, bladder or kidney infections within the last year	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any blood in your urine	<input type="checkbox"/>	<input type="checkbox"/>
10. Any problems with control of urination	<input type="checkbox"/>	<input type="checkbox"/>
11. Any hot flashes or sweating at night	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you experience vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you experience pain during intercourse	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have menstrual tension, pain, bloating or irritability around your period	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you experienced any recent breast tenderness, lumps or nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you perform monthly self breast exams	<input type="checkbox"/>	<input type="checkbox"/>
17. If you answered yes above, have you noted any lumps	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had a thermogram or mammogram within the last year	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a pap and/or pelvic exam within the last year	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you noticed a loss of muscle mass or tone	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you noticed an increase in abdominal fat	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you feel more hesitant and/or less confident	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you feel your sexual performance has declined	<input type="checkbox"/>	<input type="checkbox"/>
24. Is your hair thinning or have you noticed hair loss	<input type="checkbox"/>	<input type="checkbox"/>
25. Is your skin thinning, less elastic or less supple	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you feel it is hard to recover from physical activity	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you put on weight easily	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have trouble getting up in the morning	<input type="checkbox"/>	<input type="checkbox"/>

<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](http://www.oh-labs.com/forms.html))

**Physical Assessment**

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

Height <input type="text"/> (inches)	Weight <input type="text"/> (pounds)	Heart Rate <input type="text"/> (beats/min.)	Respirations <input type="text"/> (breaths/min.)	Blood Pressure <input type="text"/> / <input type="text"/> (systolic/diastolic)	Forced Vital Capacity <input type="text"/> (liters)	Body Fat <input type="text"/> (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     Breast lumps     Cysts     Disease     Other, specify  
 Abnormal     CS    Notes: \_\_\_\_\_

Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Age of menarche \_\_\_\_\_ Age at menopause \_\_\_\_\_ Cycle:  Regular  Irregular # days flow \_\_\_\_\_  
Date of last thermogram/mammogram \_\_\_\_\_

**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	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Chest, Breasts	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
COR	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Extremities	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Neurological	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes: _____
Pelvic Exam	<input type="checkbox"/> Normal	<input type="checkbox"/> 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](mailto:medical@oh-labs.com). Include leading "1" when sending by fax.