Patient Name: Eddie Gonzalez Date: 02/22/11
Address: [redacted] DOB: [redacted]
City: Homestead State: FL Zip: 33030
Phone: [redacted] Alt. Phone # ____
Drug Allergies: N/A

DHEA _____ mg SR Capsules
Sig: Take one capsule in am. Qty ____ Refill ____

Pregnenolone _____ mg SR Capsules
Sig: Take ____ capsule _____ daily. Qty ____ Refill ____

Compounded Thyroid (T3/T4) _____ mg
Sig: Take one capsule in am. Qty ____ Refill ____

Melatonin Capsules or Drops (Circle one)
Sig: Take ____ mg at bedtime Qty ____ Refill ____

Phentermine 37.5mg / Chromium 400mcg Capsules
Sig: Take one capsule in am. Qty # 30 No Refills

Compound Testosterone Cyplonate _____ mg/ml
Sig: Inject _____ ml every _____ wk. Qty 10ml Refill ____

Compound Testosterone Propionate _____ mg/ml
Sig: Inject _____ ml every _____ wk. Qty 10ml Refill ____

Compound Testosterone Enanthate _____ mg/ml
Sig: Inject _____ ml every _____ wk. Qty 10ml Refill ____

HCG ____ units (5,000 or 10, 000 circle one)
Sig: Inject _____ units daily. Qty 1vial Refill ____

Compound and mail prescriptions to patient. Physician will counsel patient on proper use of medication, side effects and storage.

Prescriber Signature: _____
Prescriber Name: Dr. Daniel A. Carpman
Address: 9562 NW 41st Street
City: Doral State: FL Zip: 33178
State Lic: ME99613 DEA#: FC4828808
Phone: (305) 456-3794 Fax: (305)456-1865

) Testosterone Cream 4mg transdermal #30
Apply As Directed

) L-glutathione cream transdermal #30
Apply As Directed

Testosterone Troche 20mg sublingual gel mint Flavor #30