Patient Name: DANNY HERNANDEZ Date: ___/___/___
Address: [redacted] DOB: [redacted]
City: CORAL GABLES State: FL Zip: 33146
Phone: [redacted] Alt. Phone # _____
Drug Allergies: NONE

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 Cypionate _____ 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. Arturo Perez
Address: 9562 NW 41st Street
City: Doral **State:** FL **Zip:** 33178
State Lic: ME 18355 **DEA#:** FP1513010
Phone: (305) **Fax:** (305)456-1865

1 TESTOSTERONE CREAM 4 mg/ml 6 SCENT 30 ml TRANSDERMAL APPLICATION DAILY AM
2 TESTOSTERONE SUBLINGUAL TROCHE 20 mg/ml 30 LOZENGES MINT FLAVOR qd po
3 L-GLUTATHIONE CREAM 30 ml TRANSDERMAL APPLICATION DAILY EVENING
1 PHENTERMINE 37.5 mg # 30 ONE CAP po qd AM
5 CLOMIPHENE 50 mg # 30 po qd AS DIRECTED