

**ANTI-AGING PATIENT INFORMATION FORM FOR MEN**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail address \_\_\_\_\_

Describe your main complaint(s) \_\_\_\_\_

If your complaint is due to pain, complete the following:

Location \_\_\_\_\_ Severity on a scale of 1 \_\_\_\_\_ 10

Quality \_\_\_\_\_ Duration \_\_\_\_\_

Time \_\_\_\_\_ What makes it better or worse? \_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_

**MEDICAL HISTORY:** List any other doctors you've seen for this condition \_\_\_\_\_

Who is your current family physician? \_\_\_\_\_ Specialist? \_\_\_\_\_

Date of your last physical exam \_\_\_\_\_ When did you have your last blood tests? \_\_\_\_\_

List any diagnoses or treatments \_\_\_\_\_

List any surgeries or major illness with date of occurrence \_\_\_\_\_

Have you had any infectious diseases? \_\_\_\_\_

Have you been hospitalized for this or any condition? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ Have you ever reacted to medications? \_\_\_\_\_

**MEDICATIONS:** List all prescription or over-the-counter drugs you are taking \_\_\_\_\_

**NUTRITIONAL SUPPLEMENTS:** List all vitamin, mineral, and other nutritional or herbal supplements \_\_\_\_\_

**LIFE STYLE INFORMATION:** Answer the following questions with YES or NO and explain if necessary

— Do you exercise? How often? \_\_\_\_\_ What type? \_\_\_\_\_

— Do you use alcohol? How often? \_\_\_\_\_ What kind? \_\_\_\_\_

— Do you smoke? How much? \_\_\_\_\_ For how long? \_\_\_\_\_ When did you quite? \_\_\_\_\_

— Do you drink coffee? \_\_\_\_\_

— Do you drink caffeinated sodas? \_\_\_\_\_

— Do you follow a specific diet? \_\_\_\_\_

— Are you concerned about your weight? Are you following a specific diet? \_\_\_\_\_

— Do you overeat? How is your appetite? \_\_\_\_\_ Do you have any reactions to foods? \_\_\_\_\_

— Do you crave sweets? Do you have any other food cravings? \_\_\_\_\_ Or aversions? \_\_\_\_\_

— Are you concerned about aging? Do you have a specific concern? \_\_\_\_\_

— Are you concerned about your appearance? Have you used any aesthetic therapies? \_\_\_\_\_

— Are you stressed or anxious? \_\_\_\_\_

— Do you or have you experienced depression? Is there any form of depression or dementia in your family? \_\_\_\_\_

— Do you suffer from insomnia or any other form of sleep abnormality? \_\_\_\_\_

— Are you concerned about memory loss? \_\_\_\_\_

— Do you practice any form of stress reduction such as meditation, tai chi or yoga? \_\_\_\_\_

— Is your relationship fulfilling? \_\_\_\_\_ How is your children's health? \_\_\_\_\_

— Do you experience fatigue? \_\_\_\_\_

**DIETARY INFORMATION:** Describe your daily diet \_\_\_\_\_

# BIOMARKER QUESTIONNAIRE

Name \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

## Have you experienced any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Decreasing muscle mass  | <input type="checkbox"/> Slow wound healing  |
| <input type="checkbox"/> Reduced strength  | <input type="checkbox"/> Frequent colds or flu   |
| <input type="checkbox"/> Decreased joint mobility  | <input type="checkbox"/> Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis |
| <input type="checkbox"/> Increased stiffness   | <input type="checkbox"/> Chronic pain or inflammation  |
| <input type="checkbox"/> Reduced capacity for work and exercise                                    | <input type="checkbox"/> Poor sleep  |
| <input type="checkbox"/> Decreased endurance   | <input type="checkbox"/> Waking up tired   |
| <input type="checkbox"/> Significant weight loss   | <input type="checkbox"/> Fatigue   |
| <input type="checkbox"/> Increased body fat  | <input type="checkbox"/> Longer recovery time needed after exertion  |
| <input type="checkbox"/> Increased waist to hip ratio (more fat deposits on the abdomen and waist) | <input type="checkbox"/> Forgetfulness   |
| <input type="checkbox"/> Reduced sexual drive and/or performance                                   | <input type="checkbox"/> Increasing difficulty concentrating   |
| <input type="checkbox"/> Muscle mass loss or flabbiness  | <input type="checkbox"/> Mood changes  |
| <input type="checkbox"/> Changes in body temperature   | <input type="checkbox"/> Unexplained depression  |
| <input type="checkbox"/> Sensitivity to cold or heat   | <input type="checkbox"/> Anxiety   |
| <input type="checkbox"/> Hot flashes   | <input type="checkbox"/> Increased anger or irritability   |
| <input type="checkbox"/> Dryer or thinning skin and hair   | <input type="checkbox"/> Sensitivity to certain foods  |
| <input type="checkbox"/> Brown or red spots  | <input type="checkbox"/> Craving for sugar   |
| <input type="checkbox"/> Spider veins on the skin  | <input type="checkbox"/> Alcohol intolerance   |

## Have you had any of the following tests?

- |  |  |
|--|--|
| <input type="checkbox"/> Complete Blood Count  | <input type="checkbox"/> Homocysteine                              |
| <input type="checkbox"/> Chemistry Panel   | <input type="checkbox"/> Blood Pressure                            |
| <input type="checkbox"/> PSA (Prostate Specific Antigen) and prostate exam for men over 40 | <input type="checkbox"/> Bone Density                              |
| <input type="checkbox"/> Breast Exam and Mammography for women                             | <input type="checkbox"/> Treadmill Test                            |
| <input type="checkbox"/> Pap Smear (for women)   | <input type="checkbox"/> Estrogen levels                           |
| <input type="checkbox"/> Colonoscopy   | <input type="checkbox"/> Testosterone                              |
| <input type="checkbox"/> Basal Temperature   | <input type="checkbox"/> Free testosterone                         |
| <input type="checkbox"/> 3-5 hour Glucose Tolerance Test                                   | <input type="checkbox"/> IgF-1 (a marker for human growth hormone) |
| <input type="checkbox"/> Fasting insulin   | <input type="checkbox"/> DHEA-S                                    |
| <input type="checkbox"/> Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL      | <input type="checkbox"/> Cortisol                                  |
| <input type="checkbox"/> Thyroid Studies (TSH, T4)   | <input type="checkbox"/> SHBG (sex hormone binding globulin)       |
| <input type="checkbox"/> Free T3   |  |

Name \_\_\_\_\_

**FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?**

- Heart or coronary arterial disease (congestive heart failure, angina, etc.) \_\_\_\_\_
- Atherosclerosis (hardening of the arteries) \_\_\_\_\_
- High cholesterol or other form of abnormal lipids \_\_\_\_\_
- Heart attack or stroke \_\_\_\_\_
- Diabetes or any form of metabolic disease or obesity \_\_\_\_\_
- Cancer and list type(s) \_\_\_\_\_
- Osteoporosis or any form of bone disease \_\_\_\_\_
- Thyroid disease \_\_\_\_\_
- List any other diseases in your family \_\_\_\_\_

## FATIGUE QUESTIONNAIRE

**Answer the questions below by checking each applicable box if you have ever experience any of the following:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Exhausted feelings that are not related to stress or amount of work or exercise.</li><li><input type="checkbox"/> Morning tiredness, even after a full night's sleep.</li><li><input type="checkbox"/> Depression that does not respond to antidepressants, diet, or exercise.</li><li><input type="checkbox"/> Unexplained anxiety and panic attacks.</li><li><input type="checkbox"/> Been told that I move as if in slow motion, and take too long to responds to questions.</li><li><input type="checkbox"/> A frequently low or hoarse voice (for a woman).</li><li><input type="checkbox"/> Mental sluggishness and have difficulty focusing.</li><li><input type="checkbox"/> Low sex drive and do not experience significant sexual arousal.</li><li><input type="checkbox"/> High cholesterol that has been unresponsive to diet or medications.</li><li><input type="checkbox"/> A tendency to feel cold even in warm weather.</li><li><input type="checkbox"/> Chronic aches and pains not due to accidents or exercise.</li><li><input type="checkbox"/> Carpal tunnel syndrome</li><li><input type="checkbox"/> Problems with allergies.</li><li><input type="checkbox"/> Difficulty losing weight and keeping it off.</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Very dry skin.</li><li><input type="checkbox"/> I have acne or eczema.</li><li><input type="checkbox"/> Diabetes</li><li><input type="checkbox"/> Rheumatoid arthritis or other autoimmune condition.</li><li><input type="checkbox"/> Problem with my periods, including abnormal menstrual bleeding.</li><li><input type="checkbox"/> Anemia</li><li><input type="checkbox"/> Infertility or a history of frequent miscarriages.</li><li><input type="checkbox"/> Significant menopausal symptoms.</li><li><input type="checkbox"/> A tendency to have chronic constipation even with a high fiber diet.</li><li><input type="checkbox"/> Lots of hair falling out or brittle hair.</li><li><input type="checkbox"/> Vitiligo or other unusual changes in skin color.</li><li><input type="checkbox"/> Trembling of my hands or stumbling for no reason.</li><li><input type="checkbox"/> Have a family history of thyroid disorder</li><li><input type="checkbox"/> Have previously been diagnosed with a thyroid disorder</li></ul> |
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**List any additional information you feel is important for the doctor to know:**

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**PATIENT'S SIGNATURE:** \_\_\_\_\_ **Date** \_\_\_\_\_

## FOR MEN ONLY

Name \_\_\_\_\_

**Circle your answers and follow the directions below to learn your score.**

- |  |     |    |
|--|-----|----|
| 1. Do you have less libido (sex drive)?                                    | Yes | No |
| 2. Do you have low energy?   | Yes | No |
| 3. Have you lost weight?   | Yes | No |
| 4. Have you noticed a decreased "enjoyment in life"?                       | Yes | No |
| 5. Are you sad and/or grumpy?  | Yes | No |
| 6. Have you lost height?   | Yes | No |
| 7. Are your erections not as strong?                                       | Yes | No |
| 8. Have you noticed a recent deterioration in your ability to play sports? | Yes | No |
| 9. Are you falling asleep after dinner?                                    | Yes | No |
| 10. Has there been a recent deterioration in your work performance         | Yes | No |

**If you answer "yes" to questions 1 or 7 or any 3 other questions, you may have low T.**

Adapted from Morley JE, et al. Validation of a screening questionnaire for androgen deficiency in aging males. *Metabolism*. 2000;49(9):1239-1242.

"It is now well established that testosterone levels decline with age. What has not been established is whether the decline in testosterone is associated with a symptom complex. This study examined whether certain symptoms are more commonly present in males with low bioavailable testosterone (BT) levels. These were used to evaluate a questionnaire for androgen deficiency in aging males (ADAM). The validity of the ADAM questionnaire to screen for low BT was tested in 316 Canadian physicians aged 40 to 62 years. Low BT levels were present in 25% of this population. None had elevated luteinizing hormone (LH) levels. The ADAM questionnaire had 88% sensitivity and 60% specificity. When the questionnaire was administered twice 2 to 4 weeks apart to 10 men, it was determined that the coefficient of variation was 11.5%. In a second study of 34 ADAM-positive patients, 37% of those with clearly normal BT levels demonstrated some evidence of dysphoria. Finally, in 21 patients who were treated with testosterone, improvement on the ADAM questionnaire was demonstrated in 18 ( $P = .002$ ). These data support the concept of a symptom complex associated with low BT levels in aging males. In addition, the ADAM questionnaire appears to be a reasonable screening questionnaire to detect androgen deficiency in males over 40 years of age."

**Check the questions below that pertain to you.**

- |  |  |
|--|--|
| <input type="checkbox"/> Have you been diagnosed with osteoporosis?        | <input type="checkbox"/> Do you experience hot flashes?  |
| <input type="checkbox"/> Do you have chronically dry skin?                 | <input type="checkbox"/> Do you have chronic pain?   |
| <input type="checkbox"/> Are you losing body hair, especially on the legs? | <input type="checkbox"/> Have you gained weight gradually without an obvious cause?                        |
| <input type="checkbox"/> Are you balding?                                  | <input type="checkbox"/> Are you experiencing difficulty losing weight?                                    |
| <input type="checkbox"/> Do you experience an unexplainable unhappiness?   | <input type="checkbox"/> Are you retaining fat in your abdomen (increased belly fat)?                      |
| <input type="checkbox"/> Have you become more irritable?                   | <input type="checkbox"/> Do you produce less semen so your ejaculation quantity is reduced?                |
| <input type="checkbox"/> Do you have less ability to cope with stress?     | <input type="checkbox"/> Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome? |
| <input type="checkbox"/> Are you more emotional?                           |  |
| <input type="checkbox"/> Does your body temperature fluctuate easily?      |  |



## HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, Healthcare Treatment Options or other Health Services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? YES NO

Ok to leave Message? YES NO

May we contact you at work? YES NO

Ok to Leave Message? YES NO

May we contact you VIA Cell? YES NO

Ok to Leave Message? YES NO

If it is ok to leave a message, that includes.....

Practice Name and Phone Number Only YES NO

Detailed or Specific Message YES NO

Would you like to authorize someone else to schedule, confirm, or change appointments?

If so, please provide:

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name \_\_\_\_\_

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? YES NO

### HOW DID YOU HEAR ABOUT US?

Website

The Yellow Pages / Telephone Book

A Friend or Family Member (name) \_\_\_\_\_ May we Contact Y N

Internet Search ( Google Yahoo Other \_\_\_\_\_ )

Newsletter or Mailer

An Article or Advertisement in \_\_\_\_\_

Michael P. Heim, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability) ACT on his website [www.tampahealthcenter.com](http://www.tampahealthcenter.com). I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

I understand that The Center for Health and Age Management is a fee for service practice and that I am financially responsible for all charges upon date of service.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Parent/Guardian Signature