

ANTI-AGING PATIENT INFORMATION FORM FOR WOMEN

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:

- | | |
|--|---|
| <input type="checkbox"/> Exhausted feelings that are not related to stress or amount of work or exercise. | <input type="checkbox"/> Very dry skin. |
| <input type="checkbox"/> Morning tiredness, even after a full night's sleep. | <input type="checkbox"/> I have acne or eczema. |
| <input type="checkbox"/> Depression that does not respond to antidepressants, diet, or exercise. | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Unexplained anxiety and panic attacks. | <input type="checkbox"/> Rheumatoid arthritis or other autoimmune condition. |
| <input type="checkbox"/> Been told that I move as if in slow motion, and take too long to responds to questions. | <input type="checkbox"/> Problem with my periods, including abnormal menstrual bleeding. |
| <input type="checkbox"/> A frequently low or hoarse voice (for a woman). | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Mental sluggishness and have difficulty focusing. | <input type="checkbox"/> Infertility or a history of frequent miscarriages. |
| <input type="checkbox"/> Low sex drive and do not experience significant sexual arousal. | <input type="checkbox"/> Significant menopausal symptoms. |
| <input type="checkbox"/> High cholesterol that has been unresponsive to diet or medications. | <input type="checkbox"/> A tendency to have chronic constipation even with a high fiber diet. |
| <input type="checkbox"/> A tendency to feel cold even in warm weather. | <input type="checkbox"/> Lots of hair falling out or brittle hair. |
| <input type="checkbox"/> Chronic aches and pains not due to accidents or exercise. | <input type="checkbox"/> Vitiligo or other unusual changes in skin color. |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Trembling of my hands or stumbling for no reason. |
| <input type="checkbox"/> Problems with allergies. | <input type="checkbox"/> Have a family history of thyroid disorder |
| <input type="checkbox"/> Difficulty losing weight and keeping it off. | <input type="checkbox"/> Have previously been diagnosed with a thyroid disorder |

List any additional information you feel is important for the doctor to know:

PATIENT'S SIGNATURE: _____ Date _____

FOR WOMEN ONLY

Name _____ Date _____

Age _____ Birth Date _____ Height _____ Weight _____

Date of last physical examination _____

What are your main health concerns? _____

MENSTRUAL & GYNECOLOGICAL SYMPTOM REVIEW

How old were you when you had your first period start? _____ Did you have any problems then? _____

How was your period in your twenties? _____ Thirties? _____

How is your period now (if you still are menstruating)? _____

Do you have any PMS symptoms? If yes, what are they? _____

Do you have menopausal symptoms? _____

Are you experiencing mood changes with menopause? _____

Name of your gynecologist _____ Date of last Pap smear _____

Have you had a mammogram? And when? _____ A bone density study (DXA scan)? _____

Number of children _____ Are you pregnant now? _____ Attempting pregnancy? _____

Do you have fibroids? _____ Size _____ Date of last sonogram _____

Ovarian cysts? _____ Breast cancer? _____

Is your cholesterol high? _____ Other cardiovascular risk factors _____

Do you have osteoporosis or osteopenia? _____ Do you have any urinary tract complaints? _____

Do you have any vaginal complaints? _____ How is your libido? _____

Other complaints? _____

MEDICATION REVIEW

What medications do you currently take? _____

Are you using prescription hormones? _____

Do you use any natural hormone preparations? _____

What nutritional supplements do you take? _____

Have you had any adverse reactions to medications? _____

