Patient History Report

My Medical History [100%]

1	Please briefly tell us your goals and reasons for using Metabolic Code low energy, E.D., very low test levels, aches and pains(muscle and joint) , memory issues. Used to be quite active	
2	Please describe any major medical concerns you currently have. E.D., Inflamationaround joints	
3	Are you currently suffering from any of the following conditions? (Chose as many as apply) Emphysema	
4	Any previous or current cancer? (Choose as many as apply) I do not/have not had cancer	
5	List any other current medical problems not mentioned above: essential tremors	
6	List all medications that you take regularly with the dosage and how often you take them. (Including aspirin, etc.) If none, type “None”. propranolol-160mg.ER daily, Primidone 500mg daily Topirimate 100mg daily Sertraline 100mg daily-weening off soon . C-testosterone ,creme, 10mg./4xday	
7	List all vitamins, minerals, herbs and fish oils with the dosage, and how often you take them. If none, type “None” mutivitamin Sentry mens over 50 one daily, Omega XL brand fatty acids-4 pills daily(I take to fight inflamation)	
8	List all drug allergies and the symptoms that you experience. (Such as penicillin/rash, etc.) If none, type “No drug allergies” no drug allergies	
9	Do you have any seasonal allergies?	Yes
10	Please list any prior hospitalizations. (Give reason for hospitalizations and approximate dates) Trinity Hospital Chemical Dependency Unit Feb 2016, Trinity Hospital 2012 or 2013 - total knee replacement	
11	Have you ever had surgery for any of the following reasons? (Choose as many as apply) None of the above	
12	List any other surgeries not mentioned above. (Give type of surgery and the approximate	

	dates) remove fatty tissue around nipple- trinity outpatient 2010?
13	Have you had significant contact with any of the following? (Choose as many as apply) Not applicable
14	What is your height in feet and inches? Ex. (5-6) 5-11
15	Please provide any additional information you wish to share with your doctor. my best friend James Cole highly recommends you. Get some symbiotic relationship with my hormones and some vitality in my life

My Lifestyle [100%]

16	What is your marital status? Divorced
17	How many cans of soft drink do you have on an average day? 3 to 6
18	How many cups of coffee do you have on an average day? 3 to 6
19	If you smoke cigarettes, how many years have you been smoking? I don’t smoke
20	If you smoke cigarettes, approximately how many packs per day? I don’t smoke
21	If you quit smoking cigarettes, how many years ago did you quit? 10 to 20 years ago
22	Are you currently using recreational or illegal drugs? No
23	Are you currently employed? No
24	Briefly describe the type of work you do. retired dentist
25	What was the highest level of school you completed? Doctorate
26	If you do aerobic exercise, how many times per week? I don’t do aerobic exercises
27	If you do aerobic exercise, what type and for how long? yardwork and shoveling snow does sex count?
28	If you do weight lifting exercise, how many times per week? I don’t do any strength building exercises
29	If you do weight lifting exercise, what type and for how long? I lifted hard for 20 years but can't drag myself into the gym anymore
30	If you meditate, how many times per week?

	More than 4
31	What is your sexual orientation?
	Heterosexual

My Family | (Mother) [100%]

32	Illnesses/Conditions: Osteoporosis, Breast Cancer
33	Age (current age if living / age at death if deceased): 88
34	This relative is: Deceased

My Family [0%]

35	Illnesses/Conditions:	n/a
36	Age (current age if living / age at death if deceased):	n/a
37	This relative is:	n/a

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Metabolics [100%]

Basic Health

38	Have you been told you have pre-diabetes or have insulin resistance (a fasting blood sugar level of greater than 99)?	No
39	Do you drink alcoholic beverages, more than 1-2 glasses of wine, 1-2 beers or 1-2 shots of alcohol daily?	No
40	Do you have food allergies or food intolerances?	No
41	Are you under chronic stress and/or are you anxious and have anxiety?	No
42	Do you have food cravings often?	No
43	Do you exercise regularly?	No
44	Have you tested positive for the MTHFR (methylenetratrahydrofolate reductase) gene SNP or have folate deficiency?	No
45	Have you tested positive for heavy metals?	No

Drug-Induced Nutrient Depletion

46	Do you take acetaminophen (Tylenol) regularly?	No
47	Are you taking antibiotics?	No
48	Are you taking medications for anxiety, to relax or for sleep?	No
49	Are you taking antihistamines?	No
50	Are you prescribed anticonvulsant drugs for seizures or other health condition?	Yes
51	Are you taking medications for depression or mood imbalances?	Yes
52	Are you taking medications for your blood sugar levels or diabetes?	No
53	Do you take aspirin regularly?	No
54	Are you taking medications for osteoporosis prevention and/or bone health?	No
55	Are you taking oral or inhaled corticosteroids ("steroids")?	No
56	Are you taking a medication for your cholesterol called a "statin"?	No
57	Are you taking any other medications to help lower your cholesterol other than a "statin"?	No
58	Are you taking "fluid pills" or diuretics?	No
59	Are you taking a drug for your heart called digitalis or Lanoxin?	No

60	Are you taking synthetic hormonal replacement therapy, including synthetic estrogens (including Premarin or conjugated estrogen) and/or progestins? This does not include testosterone or bio-identical hormone replacement.	No
61	Are you prescribed a beta-blocker for your heart or blood pressure?	Yes
62	Are you taking an ACE inhibitor or ARB for your blood pressure or heart condition?	No
63	Are you taking potassium prescribed by your doctor?	No
64	Are you taking prescribed medications to help improve your memory?	No
65	Do you take NSAIDs (non-steroidal anti-inflammatory drugs) like ibuprofen (Advil) or naproxen (Aleve) regularly?	Yes
66	Are you prescribed drugs for pain called opiates, including hydrocodone, codeine, morphine, meperidine (Demerol), oxycodone (Oxycontin)?	No
67	If yes to taking opiates, do these pain medications also contain acetaminophen?	No
Triad 1 - Adrenal High		
68	Is your short-term memory worse than it used to be?	Yes
69	Are you easily irritated and snap at family and co-workers?	No
70	Do you feel overcommitted throughout the day?	No
71	Do you feel there is too much stress in your life?	No
72	Do you usually eat more than 50% of your calories after 5pm?	Yes
73	Do you recover poorly from injury or illness?	No
74	Has your ability to exercise decreased?	Yes
75	Do you get upset easily, causing you to become tired and exhausted?	No
Triad 1 - Adrenal Low		
76	Is your memory, concentration or focus poor?	Yes
77	Do you crave salt or comfort foods in the late afternoon or evening?	No
78	Do you take in more than the equivalent of 3 cups of coffee a day in caffeine for energy?	Yes
79	Do you get dizzy when standing up?	No
80	Do you feel emotionally flat, less able to feel happiness or joy?	No
Triad 1 - Pancreas - Blood sugar balance		
81	Are you prescribed medications for thyroid?	No

82	Do you feel irritable if a meal is missed or get anxious/nervous/shaky if you go more than 4 hours without eating?	No
83	Do you crave carbohydrates (breads, pasta, crackers, chips, cookies, fruit drinks and sodas)?	No
84	Are you more than 20 pounds over your ideal body weight?	No
85	Do you get a headache if you go too long without eating or relieved by sweets or alcohol?	No
86	Do you get tired after eating a big meal?	Yes
87	Do you wake up at night craving carbohydrates like sweets, cookies, chips, crackers or breads?	No
88	Have you been told by your doctor that you are insulin resistant, pre-diabetic or that you are diabetic?	No
89	Do you get periodic energy crashes during the course of the day that is relieved by caffeine or food?	Yes
90	Do you get night sweats?	No
Triad 1 - Thyroid High		
91	Does your body temperature usually run low (less than 98 degrees F)?	No
92	Do you have a history of heart palpitations (abnormally rapid or irregular heart beat)?	No
93	Do you flush easily?	No
94	Do your hands shake or tremble?	Yes
95	Do you eat a lot but can't gain weight?	No
96	Do you have high energy levels, followed by exhaustion or extreme tiredness?	Yes
Triad 1 - Thyroid Low		
97	Do you easily get shaken, startled or get goose bumps?	No
98	Do you usually feel exhausted and tired from morning to night?	Yes
99	Do you have trouble getting up in the morning?	No
100	Do you have dry skin, brittle hair and/or nails?	Yes
101	Do you have difficulty losing weight regardless of diet/exercise?	No
102	Do you have cold hands and/or feet?	Yes
103	Are your eyebrows and hair thinning, especially around the edges?	No
Triad 2 - Brain		

104	Do you usually have a lack of sleep?	Yes
105	Do you usually have difficulty falling asleep?	No
106	Do you have trouble with replaying events over in your head that keep you from falling asleep?	Yes
107	Are you a restless sleeper, tossing or awakening during the night?	No
108	Do you snore to the point that other people comment?	No
109	Have you been told by your doctor that you have sleep apnea?	Yes
110	Do you sleep 5 hours or less a night?	No
111	Do you sleep between 5 and 7 hours a night?	Yes
112	Do you sleep more than 9 hours a night?	No
113	Do you eat past being full, attempting to shut off an emotional craving in your head?	No
114	Do you have frequent mood swings?	Yes

Triad 2 - Gut

115	Does your heart beat 90/min or above at rest? If so, based on your questionnaire answer, you should seek medical attention.	No
116	Have you ever taken antibiotics for acne or have you ever taken antibiotics for 2 months or longer?	No
117	Have you taken cortisone-type ("steroid") drugs, like cortisone, hydrocortisone, prednisone) periodically in your lifetime?	No
118	Do you use aspirin, ibuprofen (Advil, Motrin), naproxen (Aleve, Naprosyn) or acetaminophen (Tylenol) regularly or take prescription NSAIDs (non-steroidal anti-inflammatory drugs)?	Yes
119	Do you get athlete's foot, "jock itch" or fungus on skin or nails easily?	No
120	Do you get symptoms from damp, muggy days, or moldy places - like being tired, trouble breathing or runny nose/sneezing?	No
121	Do you have food intolerances or environmental allergies?	No
122	Do you have mental "fogginess" - like you're pushing a thought through "jello"?	Yes
123	Have you had or do you get skin rashes or eczema?	No
124	Are you frequently constipated, have diarrhea or go back and forth between the two?	Yes
125	Do you have frequent constipation? (more than once weekly)	No

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Triad 2 - Gut - Stomach Acid High

126	Do you have a history of anemia (low iron, B12, or folic acid) that doesn't respond well to treatment?	No
127	Do you have stomach pain before or after eating?	No
128	Does stomach pain get worse with stress or emotional upset?	No
129	Have you been diagnosed with an ulcer?	No
130	Are you on H2 blockers or proton pump inhibitors (PPIs)? These drugs are for indigestion and are either prescription or over-the-counter (non-prescription).	No

Triad 2 - Gut - Stomach Acid Low

131	Do you get gassy or bloated easily, especially after eating a meal?	No
132	Do you belch and burp frequently?	No
133	Do you feel full for extended periods of time after eating?	No

Triad 2 - Immune

134	Do you get frequent sinus infections or have you been diagnosed with chronic sinusitis?	No
135	Do you get frequent sore throats or throat infections?	No
136	Do you get cold sores or fever blisters often?	No
137	Do you have swollen glands often?	No
138	Do you get or have a history of frequent ear infections?	No
139	Is it difficult for you to get over a cold or the "flu"?	No
140	Do you get sick a lot?	No
141	Do you get boils or styes often?	No

Triad 2 - Immune Th2

142	Do you have itchy, watery eyes often?	No
143	Do you have heavy discharge from your eyes often?	No
144	Do you get itchy in your mouth or throat often?	No
145	Do you clear your throat frequently?	No
146	Do you have post-nasal drip (a runny nose) often?	Yes
147	Do you sneeze a lot?	No

148	Do you breathe through your mouth?	No
149	Do you have asthma or wheezing?	Yes
150	Do you have a history of herpes?	No
151	Do you have swollen joints or joint pain?	Yes
Triad 3 - Cardiovascular		
152	Do your calf muscles cramp while walking or do you experience restless leg syndrome at night?	No
153	Do you feel out of breath after walking up a flight of stairs?	Yes
154	Do you have swelling in your feet and/or ankles?	No
155	Do you experience chest pain while walking?	No
156	Do you have difficulty breathing at night?	No
157	Do you exercise regularly?	No
Triad 3 - Neurovascular		
158	Have you been told by your doctor you have high blood pressure?	No
159	Does your head feel “heavy” or imbalanced?	No
160	Do you get light-headed easy or faint?	No
161	Do you have ringing or buzzing in the ears?	No
162	Do you have a tingling or pain sensation on your body without having previous injury?	No
163	Do you have a loss of feeling in hands and/or feet (toes)?	No
164	Do your arms and legs feel too heavy to hold up?	No
165	Do you lose your balance easily?	No
166	Have you ever been told by your doctor that you have shingles?	No
Triad 3 - Pulmonary		
167	Do you have difficulty breathing?	No
168	Do you get chest pain with a deep breath?	No
169	Do you have shortness of breath?	Yes
170	Do you cough often or have to clear your throat often?	No
171	Is there rattling or mucous in your lungs when you breathe?	Yes

172	Do you live around people who smoke?	No
173	Have you ever been exposed to asbestos?	No
174	Have you been told by your doctor that you have bronchitis?	No
175	Do you smoke?	No
176	Do you live in an industrialized area with a large amount of pollution?	No
Triad 4 - Kidney		
177	Do you have pain or burning when urinating?	No
178	Do you have cloudy urine?	No
179	Do you have difficulty holding your urine?	No
180	Have you had a history of frequent urinary tract infections or cystitis?	No
Triad 4 - Liver		
181	Are you intolerant of greasy foods, like fried foods or fatty meats?	No
182	Do you have pain or discomfort in your right side under your rib cage?	No
183	Do you have a light colored or yellowish stool?	No
184	Are the whites of your eyes yellowed?	No
185	Do you have a sour taste in your mouth often?	No
186	Do you have bad breath?	No
187	Do you have excessive body odor?	No
188	Do you use acetaminophen (Tylenol), naproxen (Aleve) or ibuprofen (Advil, Motrin) more than once a week?	Yes
Triad 4 - Lymph		
189	Do you have swollen glands in neck, groin, or armpits?	No
190	Have you had lymph nodes removed?	No
191	Do you feel as though your legs have cement in them?	No
Triad 5 - Sex Hormones		
192	Do you have a history of swollen prostate or benign prostatic hyperplasia (BPH)?	No
193	Do you have a history of prostate or urinary tract infections?	No
194	Is it difficult to get your urine flowing when you first start?	No

195	Do you have a reduced urine flow or forced urination?	No
196	Do you have to urinate often?	No
197	Do you awaken frequently at the night to urinate?	No
198	Has your sex drive decreased?	No
199	Do you have a loss of general strength or stamina?	Yes
200	Have you found yourself more irritable lately?	No
201	Do you have trouble in getting an erection or maintaining an erection?	Yes
202	Do you take or use testosterone replacement therapy?	Yes