



PERSONAL HISTORY INTAKE INFORMATION

Name (First, MI, Last): Mark P. Isaacs

Date of Birth: 04 / 09 / 46 Today's Date: 09 / 07 / 2020 Age: 74

Marital Status: Married Level of Education: High School

Occupation: Gen. Contractor Retired? Yes No

Your Primary Care Provider:

Name: Tack Hung Kaiser Perm. Phone: _____

Date of Last Physical: 06 / 06 / 2020

Active Medical Problems:

Prostate Cancer PSA .03 Following Radiation
Kidney Disease #3

Prescription & over the counter medications you are currently taking (include doses):

Lisinopril one (1) Pur day 12.5 mg

Allergies – Drugs:

Tetraacycline

Allergies – Foods & Other:

Nutrients/Supplements you are currently taking & current amount:

1/3 Magnesium, C
Finivit

Patient Name: Mark P. Isaacs

HOSPITALIZATIONS Please include surgeries, illnesses, severe accidents, births, and miscarriages.

Year	Procedure	Reason	Outcome
2019	Radiation	Prostate cancer	good so far
2010?	Itimnia		

MEDICAL CONDITIONS Check any conditions you have had in the past.

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes – Type II | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Alcohol/drug problem | <input type="checkbox"/> Goiter | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Heart Disease: Type: _____ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis: Type: _____ | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hiatal Hernia/Reflux | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hypertension / High BP | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Pelvic Infl Disease |
| <input checked="" type="checkbox"/> Cancer: Please specify:
<u>Prostate</u> | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Candida / Yeast | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sjogrens |
| <input type="checkbox"/> Chronic Fatigue | <input checked="" type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Colitis: Type: _____ | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Root canal |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dermatomyositis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Diabetes – Type I | <input type="checkbox"/> Myocardial Infarction, past or asymptomatic | <input type="checkbox"/> Psychiatric hospitalization |
| | <input type="checkbox"/> Myocardial Infarction symptomatic | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Obsessive Compulsive Disorder | |

FAMILY HISTORY Please complete health Information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father			86	Liver Cancer
Mother			94	Natural
Brother(s)				
Sister(s)				

Disease	Relation
Arthritis/Gout	
Asthma/Hay Fever	
Cancer (type):	
Drugs/Alcohol	
Diabetes	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Stroke	

RECENT TESTS

Have you had any of these tests in the past 5 years?

Test	Date	Reason	Result
Chest X-Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound			
CT Scan			
MRI	2018	Prostate / Bone	all good
Bone Density (DEXA)			
Other			

HEALTH HABITS

Which substances do you consume?

Substance	How Much?	
Caffeine	cups, cans/day	
Cigarettes	packs/day	
Are you interested in quitting? Or have you quit? Y / N	When did you quit?	
Alcohol	Type	Amount
Drugs	Type	Amount
Chew Tobacco	Amount	
Nutrasweet	Servings per day:	
Saccharin	Servings per day:	
Splenda	Servings per day:	
MSG	Servings per day:	

FEMALE HORMONE REVIEW

Have you ever had any of these symptoms? Review this list of symptoms and check the ones that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Increased fat around hips/thighs | <input type="checkbox"/> Painful sex |
| <input type="checkbox"/> Bloating late in cycle | <input type="checkbox"/> Lack of periods | <input type="checkbox"/> PMS (___ days) |
| <input type="checkbox"/> Cravings for sugar, chocolate | <input type="checkbox"/> Leak Urine | <input type="checkbox"/> Polycystic Ovaries |
| <input type="checkbox"/> Cramps/clots with periods | <input type="checkbox"/> Loss of interest in sex | <input type="checkbox"/> Problems with Infertility |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Migraines late in cycle | <input type="checkbox"/> Spotting after menopause |
| <input type="checkbox"/> Facial hair | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Unusual vaginal discharge |
| <input type="checkbox"/> Fibro-cystic Breasts | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Uterine Fibroid |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal Dryness/Pain |
| <input type="checkbox"/> Irregular periods | | <input type="checkbox"/> Vaginal irritation |

Date of 1st day of last period _____ Birth control method: _____ Are you pregnant? Yes/No

Date of last Pap test _____ Normal/Abnormal

Date of last Mammogram _____ Normal/Abnormal

Date of Menopause _____ Have you ever had an abnormal pap? Yes/No When? _____

What hormones have you used in the past? _____

Any problems with these hormones? _____

MALE HORMONE REVIEW

Date of last prostate exam: 2019 Normal / Abnormal

Review this list of symptoms and check any that apply.

- Bladder not emptying completely
- Can't maintain erection
- Crooked/curved erection
- Difficulty in initiating stream
- Enlarged prostate
- Erections less firm
- Lower sex interest
- Night-time urination frequency 2 /night
- Premature ejaculation
- Slowing urinary stream

DIET Please check the most appropriate answer.

1. I consume meals prepared from scratch.
 Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
2. I eat at restaurants.
 Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
3. I eat fast foods.
 Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
4. I tend to crave/eat the following foods:
 Sugar Whole Grain Fruit Juice Alcohol Chocolate Fatty Food/Oil Bread/Pasta
5. I usually crave at the following times:
 After meals Through morning Through afternoon Evenings No specific time
6. I tend to overeat:
 Never Seldom Often
7. I drink ____ oz of water per day.
 Tap Well Bottled Distilled Filtered

WEIGHT LOSS

1. How concerned are you about your weight? (Circle, 1 = not at all, 10 = very much)
1 2 3 4 5 6 7 8 9 10
2. How much help do you need with your weight loss? (Circle, 1 = none, 10 = much)
1 2 3 4 5 6 7 8 9 10
3. How long has your weight been a problem?
 < 5 years > 5 years Lifetime Since menopause Since pregnancy Stressful event
4. Where do you tend to carry most of your weight?
 Hips and thighs Belly Face All over
5. As an adult my lowest weight has been/is: 187 Date: August '20
6. As an adult my highest weight has been/is: 207 Date: 2019
7. What type of weight loss plan worked best for you in the past? eating carefully
8. Your current weight: 189 Goal weight: 185-187

STRESS

1. Rate your overall current stress level:

Extreme High Medium Low

2. Evaluate each type of stress:

Types of Stress	Rating				Duration of Stress			Resolution Within			
	Extreme	High	Med	Low	Weeks	Months	Years	1yr	5yrs	10yrs	Never
Family/Relatives				✓							
Home				✓							
Financial				✓							
Work				✓							
Relationship with:				✓							
Illness				✓							
Illness Involving:				✓							
Transition in: Life/ Home/Relationship/ Work											
Loss of Loved One/ Work					✓						

3. Check Yes or No:

Yes No

Do you feel like your life is too busy?		✓
Do you feel burdened with life?		✓
Do you suffer from melancholy?		✓
Do you have a low sexual interest?		
Do you have a bleak attitude about life?		✓
Are you angry or frustrated with certain aspects of life?		✓
Is it hard for you to enjoy life in general?		✓
Do you envy other people who seem happier in general?		✓
Are you easily distracted?		
Are you impulsive?		○
Are you plagued with unfinished projects?		
Do you lose things or frequently misplace things?		○

SLEEP

1. How much sleep do you get at night (on average)? 7-8 Hours
2. My usual bed time is: 10 am/pm
3. My usual wake time is: 7+/-8 am/pm
4. Approximate time before falling asleep is: 15 ? minutes
5. Do you awake in the night? yes How many times? twice Why? potty Breaks

6. Check yes or no:

Yes No

I usually need an alarm to wake up.			<input checked="" type="checkbox"/>
My sleep is not restful.			<input checked="" type="checkbox"/>
I have difficulty falling asleep.			<input checked="" type="checkbox"/>
I wake at night feeling like I am choking, being smothered or kicking my legs.			<input checked="" type="checkbox"/>
My partner notices I snore heavily.			<input checked="" type="checkbox"/>
My partner notices I stop breathing through the night along with my snoring.			<input checked="" type="checkbox"/>
I have restless legs that disturb my evening or sleep.			<input checked="" type="checkbox"/>
I wake at night and it is difficult to go back to sleep.			<input checked="" type="checkbox"/>
I wake at night hungry or thinking of food.			<input checked="" type="checkbox"/>
I have daytime drowsiness or sleepiness.			<input checked="" type="checkbox"/>
If I am not active during the day I tend to fall asleep. (meetings, driving, etc.)			<input checked="" type="checkbox"/>
I am a night shift worker.			<input checked="" type="checkbox"/>
I have or might have sleep apnea.			<input checked="" type="checkbox"/>

EXERCISE

Complete ONLY if you are currently exercising.

1. Exercise (s) you participate in:

Aerobic Weights Walking Swimming Bicycling Running

Other: _____

2. How often do you exercise?

Once/wk Twice/wk Three times/wk Four times/wk Five or more times/wk

3. What is the average duration of exercise you get at one time? 20+ minutes

4. What motivates you to exercise? I always have

5. Are you experiencing difficulty with your exercise routine? Yes/No

6. If yes, please explain: _____

Please complete if you are NOT currently exercising.

1. What prevents you from exercising?

Time Interest Energy Injury Motivation

2. Do you experience pain with exercising? Yes/No

3. If you have pain, where is it located? _____

4. How do you prefer to work out?

Gym With a partner With a trainer Alone

MOTIVATION

Please reflect on the following statements and circle the most appropriate.

On a scale of 1 – 5, 1 = do not agree and 5 = strongly agree

I am prepared to make changes in my life.	1	2	3	4	5
It is important to make the changes now, not later.	1	2	3	4	5
I will find the time to exercise regularly.	1	2	3	4	5
I am willing to eat differently.	1	2	3	4	5
I am willing to take my supplements as my doctor prescribes.	1	2	3	4	5
I will take my medications as my doctor prescribes.	1	2	3	4	5
I will work with my doctor to find the right regimen for me.	1	2	3	4	5
I will not expect instant results and perfect outcomes.	1	2	3	4	5
I recognize that this is a long-term process, not a quick fix.	1	2	3	4	5

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

Adrenal

Yes No

Fainting/collapse		✓
Palpitations		✓
Salt craving		✓
Muscle tension		
Easily frustrated	sometimes	
Sweat easily – palms/armpits		✓
Sugar craving		
Panic attacks		✓
Feeling overwhelmed		✓
Excessive hunger		✓
Prone to infection/sickly		✓
Low blood pressure		✓
Light headed when standing up		✓
Racing mind, prevent sleep		✓
Sluggish in morning – slow start		✓
Need sunglasses in bright light		✓
Low back pain – worse w/ fatigue or stress	0	

Cardiovascular/Respiratory

Yes No

Chest pain		✓
Blood in sputum		✓
Unusual cough		✓
Shortness of breath		✓
Swollen Ankles		✓
Rapid heart beat		✓
Leg pain with walking		✓
Snoring excessively		✓
Fainting/collapse		✓

Metabolic, T3, or Adrenal

Yes No

Migraines		✓
Constipation		✓
Fluid Retention		✓
Crave caffeine		✓
Dry coarse skin	✓	
Deepening voice		
Dry or thinning hair	✓	
Cold hands and feet	✓	
Elevated cholesterol		
Low body temperature		✓
Fatigue/exhausted by day's end	✓	
Brittle unhealthy nails	✓	
Fibromyalgia	✓	
Chronic fatigue	✓	

Metabolic or T4

Yes No

Decreased Memory		✓
Depression		✓
Anxiety		✓
Can't multi-task as well		
Low ambition/motivation		✓
Decreased concentration	✓	
Foggy/spacey/muddled mind	✓	
Hard to follow a train of thought	✓	

Gastro-intestinal

Yes No

Fluid retention, puffy extremities		✓
Bright blood in stool		✓
Difficulty swallowing		✓
Loss of appetite		✓
Persistent nausea		✓
Bloating		✓
Abdominal pain		✓
Acid reflux		✓
Recent change in bowel habit		✓
Weight loss – unexpected		✓
Black tarry stools		✓

Urinary

Yes No

Blood in urine		✓
Urgent urination		✓
Frequent urination		✓

Hypersensitivity

Yes No

Symptoms are year-round		✓
Symptoms are seasonal		✓
Recurrent canker sores		✓
Diarrhea alt. with constipation		✓
Dandruff/itchy scalp		✓
Eczema/Dermatitis		✓
Dizziness		✓
Wheezing		✓
Chronic cough		✓
Sinus congestion		✓
Nasal congestion		✓
Excessive mucus		✓

Neuro-Cognitive/Psych

Yes No

Loss of self-esteem		✓
Feeling of hopelessness		✓
Feeling defeated		✓
Loss of confidence		✓
Mood swings		✓
Sense of powerlessness		✓
Decreased sense of well-being		✓
Apathy/losing interest in life		✓
Vision deteriorating		✓
Hearing deteriorating		✓
Memory deteriorating		✓
Balance deteriorating		✓
Coordination deteriorating		✓
Change in headaches		✓
Double vision		✓
Dizzy/spinning		✓

Metabolism

Yes No

Excessive Thirst		✓
Cannot skip meals		✓
Headache if meal is missed		✓
Craving for sugar and carbs		✓
Mid-afternoon drowsiness		✓
Low energy periods relieved with food		✓
Jittery/irritable episodes – relieved with food		✓
Alt. bet. high/low moods		✓
Alt. bet. sluggish/high energy		✓
High blood pressure		✓
Skin tags at neck/armpits		✓
High cholesterol/triglycerides		✓
Increased fat around abdomen		✓
Prone to inflammation		✓

Immune System

Yes No

Frequent colds or flu		✓
Rash across face and cheeks		✓
Patchy red rash on body		✓
Arthritis in fingers/hands		✓
Asthma/Wheezing		✓
Patchy hair loss		✓

Other

Yes No

Unusual bruising		✓
Nose bleeds		✓
Prolonged bleeding		✓

AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: Mark P. Isaacs
 Address: 7551 123rd Ave NE, Kirkland, 98033
 SSN: 549-47-3389 Date of Birth: 04/09/46
 Name of Clinic or Physician: Jack Hung Kaiser - Redmond
 Address:
 Phone: _____ Fax: _____

I authorize the above-named individual or organization to disclose the above named patient's health information as described below, to the following recipient: **Longevity Medical Clinic Copies of all responsive documents should be mailed to the following address: 9757 NE Juanita Drive, Suite 200, Kirkland, WA 98034 or faxed to 425-576-0894, for continuing medical care.**

INFORMATION TO BE RELEASED

- Current CBC, CMP, Cholesterol and any hormone testing. For men, last PSA.
- Current History and Physical.
- For women, current PAP report and mammogram report.
- Current colonoscopy report.

Information obtained from the above-named individual or organization shall not be disclosed to anyone other than representatives of Longevity Medical Clinic to conduct a personal review of disclosed information and to orally discuss this information to develop a plan of care at Longevity Medical Clinic. I understand that the information provided may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed.

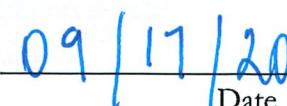
REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Longevity Medical Clinic, at the address set forth above. The revocation will not apply to records and information that have already been provided.

EXPIRATION: This authorization will expire when the request has been filled. PHOTOCOPIES OF THE AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner described above.



Patient / Legal Representative Signature



Date