

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

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

Year	Procedure	Reason	Outcome
05-1960	birth		healthy baby
03-1962	"		"
05-1965	"		"
04-1970	"		"
02-2013	Breast Cancer & 2 surgeries Mar + April R-Breast - good		

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD   | <input checked="" type="checkbox"/> Diabetes – Type II                | <input type="checkbox"/> Obstructive Sleep Apnea              |
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Emphysema                                    | <input checked="" type="checkbox"/> Osteoporosis 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"/> Goiter | <input type="checkbox"/> Panic Disorder                       |
| <input type="checkbox"/> Alcohol/drug problem   | <input type="checkbox"/> Heart Disease: Type: _____                   | <input type="checkbox"/> Parkinson's                          |
| <input type="checkbox"/> Anorexia/Bulimia   | <input type="checkbox"/> Hepatitis A, B, or C                         | <input type="checkbox"/> Pneumonia                            |
| <input type="checkbox"/> Arthritis: Type: _____   | <input type="checkbox"/> High cholesterol                             | <input type="checkbox"/> Polio                                |
| <input type="checkbox"/> Atrial Fibrillation  | <input type="checkbox"/> Hiatal Hernia/Reflux                         | <input type="checkbox"/> Psoriasis                            |
| <input type="checkbox"/> Bipolar Disorder   | <input type="checkbox"/> Hypertension / High BP                       | <input type="checkbox"/> Rheumatic Fever                      |
| <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Gout   | <input type="checkbox"/> Rheumatoid Arthritis                 |
| <input type="checkbox"/> Back pain  | <input type="checkbox"/> Irritable Bowel                              | <input type="checkbox"/> Pelvic Infl Disease                  |
| <input checked="" type="checkbox"/> Cancer: Please specify:<br><i>R-Breast - not in lymph nodes</i> | <input type="checkbox"/> Jaundice                                     | <input checked="" type="checkbox"/> Sinusitis                 |
| <input type="checkbox"/> Candida / Yeast  | <input type="checkbox"/> Kidney Disorder                              | <input type="checkbox"/> Sjogrens                             |
| <input type="checkbox"/> Chronic Fatigue  | <input type="checkbox"/> Kidney Stones                                | <input type="checkbox"/> Stroke / TIA                         |
| <input type="checkbox"/> Colitis: Type: _____   | <input type="checkbox"/> Liver Disease                                | <input type="checkbox"/> Thyroid problem                      |
| <input type="checkbox"/> Coronary Artery Disease  | <input type="checkbox"/> Lupus  | <input checked="" type="checkbox"/> Root canal                |
| <input type="checkbox"/> Crohn's Disease  | <input type="checkbox"/> Migraines                                    | <input type="checkbox"/> TMJ                                  |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Multiple Sclerosis                           | <input type="checkbox"/> Ulcers                               |
| <input type="checkbox"/> Dermatomyositis  | <input type="checkbox"/> Myocardial Infarction, past or asymptomatic  | <input type="checkbox"/> Urinary Infection                    |
| <input type="checkbox"/> Diabetes – Type I  | <input type="checkbox"/> Myocardial Infarction symptomatic            | <input type="checkbox"/> Psychiatric hospitalization          |
|   | <input type="checkbox"/> Obsessive Compulsive Disorder                | <input type="checkbox"/> Other:                               |

## FAMILY HISTORY Please complete health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father			87 1/2	
Mother			73	heart attack
Brother(s)				
Sister(s)			69	Alzheimers

Disease	Relation
Arthritis/Gout	
Asthma/Hay Fever	
Cancer (type): ovarian mother	
Drugs/Alcohol	
Diabetes	
Heart Disease only before death mother	
High Blood Pressure	
Osteoporosis	Mother
Stroke at 72	Father

## RECENT TESTS

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

Test	Date	Reason	Result
Chest X-Ray	2 - '13		
EKG			
EGD (Stomach)			
Colonoscopy	March 17	I do every 5 yrs.	1 polyp
Ultrasound			
CT Scan	'13		
MRI	Mar. '13	to see where cancer was	
Bone Density (DEXA)	02 - '13		
Other			

## HEALTH HABITS

Which substances do you consume? *(Don't take any of substances)*

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 checked="" type="checkbox"/> Increased fat around hips/thighs <i>Stomach</i> | <input type="checkbox"/> Painful sex               |
| <input type="checkbox"/> Bloating late in cycle                   | <input type="checkbox"/> Lack of periods  | <input type="checkbox"/> PMS ( ____ days)          |
| <input checked="" type="checkbox"/> Cravings for sugar, chocolate | <input type="checkbox"/> Leak Urine   | <input type="checkbox"/> Polycystic Ovaries        |
| <input checked="" type="checkbox"/> Cramps/clogs 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 age 50 Birth control method: \_\_\_\_\_ Are you pregnant? Yes/No \_\_\_\_\_

Date of last Pap test age 60/99 Normal/Abnormal

Date of last Mammogram 2 - 2020 Normal/Abnormal

Date of Menopause age 50 Have you ever had an abnormal pap? Yes/No When? \_\_\_\_\_

What hormones have you used in the past? fosamax only took for 2 yrs

Any problems with these hormones? I didn't think it was good for me

## MALE HORMONE REVIEW

Date of last prostate exam: \_\_\_\_\_ 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 \_\_\_\_\_ /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 ~~8x5~~ 5 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: 122 Date: 1965
6. As an adult my highest weight has been/is: 180 Date: 2019
7. What type of weight loss plan worked best for you in the past? eat less carbohydrates
8. Your current weight: 175 Goal weight: 155 or less

## 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:			✓					4			
Transition in: Life/ Home/Relationship/ Work											
Loss of Loved One/ Work			✓					5			

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?	Genetoxies
Do you lose things or frequently misplace things?	✓

## SLEEP

- How much sleep do you get at night (on average)? 7 Hours
- My usual bed time is: 1030-11 am/pm
- My usual wake time is: 730-8 am/pm
- Approximate time before falling asleep is: 1 hr. minutes
- Do you awake in the night? yes How many times? 3-4 Why? go to bathroom

6. Check yes or no:

Yes No

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

## EXERCISE

Complete ONLY if you are currently exercising.

1. Exercise (s) you participate in:

Aerobic     Weights     Walking     Swimming     Bicycling     Running

Other: has changed this year - no gyms

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? 1 1/2 minutes hours

4. What motivates you to exercise? I feel better, I know how important it is, I do take care of my 1/3 acre w/weeding, trimming, putting mulch down etc.

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

## DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

### Adrenal

Yes      No

Fainting/collapse		✓
Palpitations		✓
Salt craving		✓
Muscle tension		✓
Easily frustrated		✓
Sweat easily – palms/armpits		✓
Sugar craving	Sometimes	
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		✓

### Cardiovascular/Respiratory

Yes      No

Chest pain		✓
Blood in sputum		✓
Unusual cough		✓
Shortness of breath		✓
Swollen Ankles	Calf	Sometimes
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		✓

### Metabolism

Yes No

Excessive Thirst		✓
Cannot skip meals		✓
Headache if meal is missed		✓
Craving for sugar and carbs	Sometimes	
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		✓

### 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		Sometime
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		✓

### Other

Yes No

Unusual bruising		✓
Nose bleeds		✓
Prolonged bleeding		✓

**AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS**

Patient Name: Clarlene A Haymond  
Address: 3010 7-16th ave S.W Federal Way, WA 98023  
SSN: 532 - 38 - 1622 Date of Birth: 11 - 11 - 1939  
Name of Clinic or Physician: \_\_\_\_\_  
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.

Clarlene A. Haymond

Patient / Legal Representative Signature

09-21-2020

Date