



Personal History Intake Information

Today's Date: 10-7-09

First Name: DAVID Last Name: DURANT Birth Date: 4/15/61 Age: 48

Marital Status: MARIED Level of Education: H.S.

Occupation: INVESTOR Retired? Y / N

Your Primary Care Provider: Name: Dr. Vincient LEVET Phone: 253 851-5121

Active Medical Problems:

HIGH CHOLESTEROL

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

2 Motrin Twice Weekly

Allergies – Drugs:

NO

Allergies – Foods & Other:

NO

Nutrients/Supplements you are currently taking:

1-2,000, 3 Times Weekly



Patient Goal Sheet

Longevity patients have the greatest success on our program when we have a clear understanding of their health goals. These goals may change as you see your health improving. We will ask you to communicate your goals to us on a regular basis to ensure that you are completely satisfied with your Longevity program. Place a check mark next to the statements that best describe your goals.

- | | |
|--|---|
| <input checked="" type="checkbox"/> lose weight | — lower dementia risk |
| <input checked="" type="checkbox"/> increase strength/muscle | <input checked="" type="checkbox"/> lower cancer risk |
| — improve libido/sexual function | <input checked="" type="checkbox"/> improve sleep |
| — lower diabetic risk | — decrease pain |
| — improve diabetes control | — balance hormones |
| — lower blood pressure | <input checked="" type="checkbox"/> increase energy |
| <input checked="" type="checkbox"/> improve cholesterol levels | — increase stamina |
| — treat menopausal symptoms | <input checked="" type="checkbox"/> improve memory |
| <input checked="" type="checkbox"/> improve mental function | — increase bone density |
| <input checked="" type="checkbox"/> improve fatigue | — improve skin appearance |

Other areas of your health you would like to improve:

Hospitalizations: Please include surgeries, illnesses, severe accidents, births, miscarriages:

Year: Procedure: Reason: Outcome:

1970	2 - BROKEN WRISTS	FAUL	GOOD

Medical Conditions: Check any conditions you have had in the past

- ADD/ADHD
- AIDS / HIV+ 042
- Allergies/Asthma
- Anemia
- Alcohol/drug problem
- Anorexia / Bulimia
- Arthritis
- Atrial Fibrillation
- Bipolar Disorder
- Bleeding Disorder
- Back pain
- Cancer. Please specify:

- Candida / Yeast
- Chronic Fatigue
- Colitis. Type:

- Coronary Artery Disease
- Crohn's Disease
- Emphysema
- Epilepsy/Seizure
- Fibromyalgia
- Depression
- Dermatomyositis
- Diabetes – Type I
- Diabetes – Type II
- Goiter
- Heart Disease
- Hepatitis
- High cholesterol
- Hiatal Hernia/Reflux
- Hypertension / High BP
- Gout
- Irritable Bowel
- Jaundice
- Kidney Disorder
- Kidney Stones
- Liver Disease
- Lupus
- Migraines
- Multiple Sclerosis
- Myocardial Infarction, past or asymptomatic
- Myocardial Infarction symptomatic
- Obsessive Compulsive Disorder
- Obstructive Sleep Apnea
- Osteoporosis
- Pancreatitis
- Panic Disorder
- Parkinson's
- Pneumonia
- Polio
- Psoriasis
- Rheumatic Fever
- Rheumatoid Arthritis
- Pelvic Infl Disease
- Sinusitis
- Sjogrens
- Stroke / TIA
- Thyroid problem
- Root canal
- TMJ
- Ulcers
- Urinary Infection
- Psychiatric hospitalization
- Other: _____

Family History: Please complete health information about your family:

Relation	Age:	State of Health	Age at Death	Cause of death
Father	85	GOOD		
Mother	84	MEMORY		
Brother(s)				
Sister(s)	59	GOOD		
	55	GOOD		

Check if in family history	
Disease:	Relation:
Arthritis / Gout	
Asthma / Hay Fever	
<input checked="" type="checkbox"/> Cancer:	MOTHER
Drugs / Alcohol	
Diabetes	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Stroke	
<input checked="" type="checkbox"/> Alzheimer's	MOTHER 2.

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	2008	SORE KNEES	OK, No osteo or Bony Up Muscle Mass
Bone Density (DEXA)			
Other			

Health Habits:

Which substances do you consume?

Substance	How Much?		
Caffeine	4 cups	(TOTAL 200z)	cups, cans/day
Cigarettes	NO		packs / day x yr
Are you interested in quitting?	Y / N		
Alcohol	Type BEER	Amount 5 Beers per wk, Vodka, Tequila, Rum in small amounts	
Drugs	Type	Amount	
Chew Tobacco	Amount	x	yr
Nutrasweet	Serving per day:		
Saccharin	Serving per day:	Diet Cokes ?	
Splenda	Serving per day:		
MSG	Serving per day:		

Women Hormone Review:

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

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

Date of 1st day of last period: _____ Birth control method: _____ Are you pregnant? Y / N
Date of last Pap test _____ normal / abnormal Date of last Mammogram _____ normal / abnormal
Date of Menopause: _____ Have you ever had an abnormal pap? Y / N When? _____
What hormones have you used in the past? _____
Any problems with these hormones? _____

For Men:

Date of last prostate exam: 2008 normal/abnormal
Review this list of symptoms and check any that apply.

- | | | |
|-----------------------------------|---|--|
| — Bladder not emptying completely | <input checked="" type="checkbox"/> Difficulty in initiating stream | — Night-time urination |
| — Can't maintain erection | <input type="checkbox"/> Enlarged prostate | — Premature ejaculation |
| — Crooked / curved erection | <input type="checkbox"/> Erections less firm | <input checked="" type="checkbox"/> Slowing urinary stream |
| | <input type="checkbox"/> Lower sex interest | |

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 16 oz of water per day
 Tap Well Bottled Distilled

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: 174 Date: 2007

6. As an adult my highest weight has been/is: 205 Date: 2009

7. What type of weight loss plan worked best for you in the past? Diet + Exercise

8. Your current weight: 190 Goal weight: 170

STRESS

1. Rate your overall current stress level:

Extreme High Medium Low

2. Evaluate each type of stress:

Types of Stress (check as appropriate)	Rating				Duration of Stress			Resolution Within			
	Extreme	High	Med	Low	Weeks	Months	Years	1yr	5yrs	10yrs	Never
Family/Relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Home	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Relationship With: <i>Kids + Wife</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness Involving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transition in: Life/Home/Relationship /Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of: Loved one/work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- How much sleep do you get at night (on average)? 7 hours
- My usual bed time is: 10:30 am/pm
- My usual wake time is: 5:30 am/pm
- Approximate time before falling asleep is: 25 minutes
- Do you awake in the night? How many times? 2 Why? Don't Know
- Check yes or no:

	Yes	No
I usually need an alarm to wake up.	✗	
My sleep is not restful.	✗	
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.		✗
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: _____

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? _____ minutes

4. What motivates you to exercise?

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? ELBO + RT KNEE

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

(5)

It is important to make the changes now, not later.

1 2 3 4 5

(5)

I will find the time to exercise regularly.

1 2 3 4 5

(5)

I am willing to eat differently.

1 2 3 4 5

(5)

I am willing to take my supplements as my doctor prescribes.

1 2 3 4 5

(5)

I will take my medications as my doctor prescribes.

1 2 3 4 5

(5)

I will work with my doctor to find the right regimen for me.

1 2 3 4 5

(5)

I will not expect instant results and perfect outcomes.

1 2 3 4 5

(5)

I recognize that this is a long-term process, not a quick fix.

1 2 3 4 5

(5)

Rev Sept 2009

Do you currently have any of the following symptoms?

Metabolic, T3, or Adrenal	Yes	No
Migraines		X
Constipation		X
Fluid Retention		X
Crave caffeine	X	
Dry coarse skin	X	
Deepening voice		X
Dry or thinning hair	X	
Cold hands and feet		X
Elevated cholesterol	X	
Low body temperature		X
Fatigue/exhausted by day's end	X	
Brittle healthy nails		
Fibromyalgia		
Chronic fatigue	X	

Cardiovascular/Respiratory	Yes	No
Chest pain	X	
Blood in sputum		X
Unusual cough		X
Shortness of breath		X
Swollen Ankles		X
Rapid heart beat		X
Leg pain with walking		X
Snoring excessively		X

Metabolic or T4	Yes	No
Decreased Memory	X	
Depression		X
Anxiety		X
Can't multi-task as well		X
Low ambition/motivation	X	
Decreased concentration	X	
Foggy/spacey/muddled mind	X	
Hard to follow a train of thought	X	

Gastro-Intestinal	Yes	No
Fluid retention, puffy extremities		X
Bright blood in stool		X
Difficulty swallowing		X
Loss of appetite		X
Persistent nausea		X
Bloating		X
Abdominal pain		X
Acid reflux		X
Recent change in bowel habit		X
Weight loss – unexpected		X
Black tarry stools		X
Fainting/collapse		X

Adrenal	Yes	No
Fainting/collapse		X
Palpitations		
Salt craving		X
Muscle tension		X
Easily frustrated		X
Sweat easily – palms/armpits		X
Sugar craving		X
Panic attacks		X
Feeling overwhelmed		X
Excessive hunger		X
Prone to infection/sickly		X
Low blood pressure		
Light headed when standing up		X
Racing mind, prevent sleep		X
Sluggish in morning – slow start		X
Need sunglasses in bright light		X
Low back pain – worse w/ fatigue or stress		X

Urinary	Yes	No
Blood in urine		X
Urgent urination		X
Frequent urination	X	

Hypersensitivity	Yes	No
Symptoms are year-round		
Symptoms are seasonal		
Irritated tongue		X
Recurrent canker sores		X
Diarrhea alt. with constipation		X
Dandruff/itchy scalp		X
Eczema/Dermatitis		X
Dizziness		X
Wheezing		X
Chronic cough		X
Sinus congestion		X
Nasal congestion		X
Excessive mucus		X

Metabolism	Yes	No
Excessive Thirst	X	
Cannot skip meals	X	
Headache if meal is missed	X	
Craving for sugar and carbs	X	
Mid-afternoon drowsiness	X	
Low energy periods relieved w/ food		
Jittery/irritable episodes – relieved with food	X	
Alt. bet. high/low moods		
Alt. bet. sluggish/high energy		
High blood pressure	X	
Skin tags at neck/armpits	X	
High cholesterol/triglycerides		
Increased fat around abdomen	X	
Prone to inflammation/bursitis	X	

Neurocognitive/Psych Cont'd	Yes	No
Change in headaches	X	
Double vision	X	
Dizzy/spinning	X	

Immune System	Yes	No
Frequent colds or flu	X	
Rash across face and cheeks	X	
Patchy red rash on body	X	
Arthritis in fingers/hands	X	
Asthma/Wheezing	X	
Patchy hair loss	X	

Other	Yes	No
Unusual bruising	X	
Nose bleeds	X	
Prolonged bleeding	X	

Neuro-Cognitive/Psych	Yes	No
Loss of self-esteem	X	
Feeling of hopelessness	X	
Feeling defeated	X	
Loss of confidence	X	
Mood swings	X	
Sense of powerlessness	X	
Decreased sense of well-being	X	
Apathy/losing interest in life	X	
Vision deteriorating	X	
Hearing deteriorating	X	
Memory deteriorating	X	
Balance deteriorating	X	
Coordination deteriorating	X	

SKIN CARE

Are you concerned with any of the following?	Yes	No	Comments:
Dry skin	X		Tops of Forearms
Fine lines/wrinkles	X		
Sun damage			
Age spots/pigmentation	X		
Course texture	X		
Oily skin	X		
Acne/blemishes	X		
Rosacea	X		
Redness	X		
Skin tone/appearance	X		Facial Skin
Large pores	X		
Maintaining healthy skin	X		
Thinning skin – hands, face, arms	X		
Thinning hair – scalp, armpits, legs	X		
Tendency to bruise	X		
Thin, brittle nails	X		
Graying hair	X		
Thin lips	X		
Is there something about your skin you wish you could change/improve?			Facial youth.
What is your current skin care regimen?			SPF 50 on Summer Days.

Would you like a complimentary consultation with one of our aesthetic doctors or aestheticians?

Yes / No

Comments:

Maybe in the future once my health issues improve.