Patient Name: Diane Gibson

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

Year	Procedure	Reason	Outcome

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

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Allergies/Asthma
- ☐ Anemia
- ☐ Alcohol/drug problem
- ☐ Anorexia/Bulimia
- ☐ Arthritis: Type:_____
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☒ Back pain
- ☐ Cancer: Please specify:

_____

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

_____

- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Dermatomyositis
- ☐ Diabetes – Type I
- ☐ Diabetes – Type II
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Fibromyalgia ☐ Goiter
- ☐ Heart Disease: Type:_____
- ☐ Hepatitis A, B, or C
- ☐ 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	88	Kidney		Kidney
Mother	79			heart
Brother(s)	67			
	71			
Sister(s)	73			

Disease	Relation
Arthritis/Gout	
Asthma/Hay Fever	
Cancer (type):	
Drugs/Alcohol	
Diabetes	Father
Heart Disease	mother
High Blood Pressure	
Osteoporosis	mother
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	back, neck	
Bone Density (DEXA)	2020		
Other			

HEALTH HABITS *Which substances do you consume?*

Substance	How Much?
Caffeine X	cups, cans/day ½ cup
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.*

- ☐ Acne
- ☐ Bloating late in cycle
- ☐ Cravings for sugar, chocolate
- ☐ Cramps/clots with periods
- ☐ Endometriosis
- ☐ Facial hair
- ☐ Fibro-cystic Breasts
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Increased fat around hips/thighs
- ☐ Lack of periods
- ☐ Leak Urine
- ☐ Loss of interest in sex
- ☐ Migraines late in cycle
- ☐ Mood swings
- ☐ Ovarian Cysts
- ☐ Painful periods
- ☐ Painful sex
- ☐ PMS (___days)
- ☐ Polycystic Ovaries
- ☐ Problems with 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? 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? Natural cream International women phy

Any problems with these hormones? NO

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 236 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: 115 Date: _____

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

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

8. Your current weight: 115 Goal weight: 115

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				X							
Home				X							
Financial				X							
Work				X							
Relationship with:											
Illness				X							
Illness Involving:											
Transition in: Life/ Home/Relationship/ Work											
Loss of Loved One/ Work				X							

3. Check Yes or No:

	Yes	No
Do you feel like your life is too busy?		X
Do you feel burdened with life?		X
Do you suffer from melancholy?		X
Do you have a low sexual interest?		X
Do you have a bleak attitude about life?		X
Are you angry or frustrated with certain aspects of life?		X
Is it hard for you to enjoy life in general?		X
Do you envy other people who seem happier in general?		X
Are you easily distracted?		X
Are you impulsive?		X
Are you plagued with unfinished projects?		X
Do you lose things or frequently misplace things?		X

SLEEP

1. How much sleep do you get at night (on average)? 7/8 Hours
2. My usual bed time is: 12:00 am/pm
3. My usual wake time is: 8:30 am/pm
4. Approximate time before falling asleep is: min minutes
5. Do you awake in the night? yes How many times? 1 to 2 Why? go to the bathroom

6. Check yes or no:

	Yes	No
I usually need an alarm to wake up.	X	
My sleep is not restful.	X	
I have difficulty falling asleep.		X
I wake at night feeling like I am choking, being smothered or kicking my legs.		X
My partner notices I snore heavily.		X
My partner notices I stop breathing through the night along with my snoring.		X
I have restless legs that disturb my evening or sleep.		X
I wake at night and it is difficult to go back to sleep.		X
I wake at night hungry or thinking of food.		X
I have daytime drowsiness or sleepiness.		X
If I am not active during the day I tend to fall asleep. (meetings, driving, etc.)		X
I am a night shift worker.		X
I have or might have sleep apnea.		X

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? 15 minutes

4. What motivates you to exercise?_____

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

6. If yes, please explain: back

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? back / neck

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		
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	X	

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		

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

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	X	
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	X	
Increased fat around abdomen	X	
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		
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		

LONGEVITY MEDICAL CLINIC™

Feel Younger · Live Better

AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: Diane Gipson
Address: 6629 58TH AVE EAST
SSN: ___-___-___ Date of Birth: 5/19/50
Name of Clinic or Physician: Dr Bruce Baker
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: 3315 S. 23rd Street, Suite 204, Tacoma, WA 98405 or faxed to (253) 472-4140, 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.

Diane Gipson
Patient / Legal Representative Signature

9/26/20
Date