

Patient Name: LINDA Shelton 9/30/2020 425-922-1887

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

Year	Procedure	Reason	Outcome
1966	BIRTH		FINE
1975	total hysterectomy	endometriosis	ok, procedure postponed too long
2010 ?	gallbladder removed	emergency removal	poor after care
1998	AUTO ACCIDENT /whiplash hi speed Rear Impact NOT HOSPITALIZED	TBI - memory, lower back inner ear damage	OK

## 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 checked="" 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 checked="" type="checkbox"/> Hypertension / High BP                           | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input checked="" type="checkbox"/> Back pain          | <input type="checkbox"/> Gout  | <input type="checkbox"/> Pelvic Infl Disease         |
| <input type="checkbox"/> Cancer: Please specify:       | <input type="checkbox"/> Irritable Bowel   | <input type="checkbox"/> Sinusitis                   |
| <hr/>  | <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Sjogrens                    |
| <input type="checkbox"/> Candida / Yeast               | <input type="checkbox"/> Kidney Disorder   | <input type="checkbox"/> Stroke / TIA                |
| <input checked="" type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Kidney Stones   | <input type="checkbox"/> Thyroid problem             |
| <input type="checkbox"/> Colitis: Type:                | <input type="checkbox"/> Liver Disease   | <input checked="" type="checkbox"/> Root canal       |
| <hr/>  | <input type="checkbox"/> Lupus   | <input type="checkbox"/> TMJ                         |
| <input type="checkbox"/> Coronary Artery Disease       | <input checked="" type="checkbox"/> Migraines frequent headaches sometimes migraines | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Crohn's Disease               | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Urinary Infection           |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Myocardial Infarction, past or asymptomatic                 | <input type="checkbox"/> Psychiatric hospitalization |
| <input type="checkbox"/> Dermatomyositis               | <input type="checkbox"/> Myocardial Infarction symptomatic                           | <input type="checkbox"/> Other:                      |
| <input type="checkbox"/> Diabetes – Type I             | <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	deceased		69	STROKE
Mother	deceased	arthritis	61	Heart Attack
Brother(s)	deceased		22	military accident
"	deceased		55	STROKE
"	deceased		69	lung cancer
Sister(s)	—			
daughter	now 54	endometriosis breast cancer	—	

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

## 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			
Bone Density (DEXA)			
Other			

## HEALTH HABITS

*Which substances do you consume?*

Substance	How Much?
Caffeine	cups, cans/day <i>2 cups coffee / day</i>
Cigarettes	packs/day <i>∅ Never smoked, parents heavy smokers</i>
Are you interested in quitting? Or have you quit? Y / N	When did you quit?
Alcohol	Type <i>Beer Wine</i> Amount <i>1 per week 2-3 x week</i>
Drugs	Type <i>∅</i> Amount
Chew Tobacco	Amount <i>∅</i>
Nutrasweet	Servings per day: <i>∅</i>
Saccharin	Servings per day: <i>∅</i>
Splenda	Servings per day: <i>∅</i>
MSG	Servings per day: <i>∅</i>

## 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 | <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 checked="" type="checkbox"/> Endometriosis      | <input type="checkbox"/> Migraines late in cycle                     | <input type="checkbox"/> Spotting after menopause        |
| <input checked="" 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 checked="" type="checkbox"/> Vaginal Dryness/Pain |
| <input type="checkbox"/> Irregular periods             |  | <input type="checkbox"/> Vaginal irritation              |
| <input checked="" type="checkbox"/> HAIR LOSS          |  |  |

Date of 1st day of last period 1975 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? premarin, very low dosage

Any problems with these hormones? \_\_\_\_\_

## 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 40+ 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: ~ 100 lb Date: Feb 1975
6. As an adult my highest weight has been/is: ~ 200 lb Date: current
7. What type of weight loss plan worked best for you in the past? ORIGINAL weight watchers program
8. Your current weight: ~ 200 lb Goal weight: 130

## 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 <i>Retired</i>											
Relationship with:											
Illness											
Illness Involving: <i>endometriosis/hysterectomy</i> auto accident	✓							✓	✓		✓
Transition in: Life/ Home/Relationship/ Work	✓										
Loss of Loved One/ Work <i>mother's death</i> <i>father's death</i>	✓	✓						✓	✓		

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?	✗ currently	
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)? 6 Hours
- My usual bed time is: 9:30-11:00 am/pm
- My usual wake time is: 7-8am am/pm
- Approximate time before falling asleep is: ~45 minutes
- Do you awake in the night? Yes How many times? 2-3 time Why? assorted, have a very hard time going back to sleep

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.	Leg cramps	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.	?	

## 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? knees, legs, lower back, shoulders (arthritis)

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	X	
Palpitations ? what is this		
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	X	
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	

### Metabolic or T4

Yes      No

Decreased Memory NORMAL amount	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

### Cardiovascular/Respiratory

Yes      No

Chest pain	very occasionally / infrequent	
Blood in sputum		X
Unusual cough		X
Shortness of breath	X	
Swollen Ankles	X	
Rapid heart beat	X	
Leg pain with walking	yes back pain	
Snoring excessively		X
Fainting/collapse		X

### Metabolic, T3, or Adrenal

Yes      No

Migraines	X	
Constipation		X
Fluid Retention	X	
Crave caffeine	X AM	
Dry coarse skin		X
Deepening voice		X
Dry or thinning hair	X	
Cold hands and feet	I have hot feet & sleep hot	X
Elevated cholesterol	not sleep hot ?	
Low body temperature		X
Fatigue/exhausted by day's end	X	
Brittle unhealthy nails	X	
Fibromyalgia	?	
Chronic fatigue	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	

### Metabolism

Yes No

Excessive Thirst <i>drink a lot of water</i>	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 with food	X	
Jittery/irritable episodes – relieved with food	X	
Alt. bet. high/low moods	X	
Alt. bet. sluggish/high energy	X	
High blood pressure	X	
Skin tags at neck/arm pits	X	
High cholesterol/triglycerides ?		
Increased fat around abdomen	X	
Prone to inflammation ?		

*is arthritis inflammation*

### 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	

### Urinary

Yes No

Blood in urine		X
Urgent urination		X
Frequent urination		X

### Hypersensitivity

Yes No

Symptoms are year-round		
Symptoms are seasonal	<i>SNEEZING? allergies?</i>	
Recurrent canker sores		X
Diarrhea alt. with constipation		X
Dandruff/itchy scalp		X
Eczema/Dermatitis		X
Dizziness <i>auto accident</i>		X
Wheezing		X
Chronic cough		X
Sinus congestion		X
Nasal congestion		X
Excessive mucus		X

*a lot of this is related to the Covid + lockdown + political atmosphere*

### Neuro-Cognitive/Psych

Covid + lockdown 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 <i>off/on minor</i>		X
Coordination deteriorating		X
Change in headaches		X
Double vision <i>(proptosis)</i>		X
Dizzy/spinning <i>(related to car accident)</i>		X

### Other

Yes No

Unusual bruising		X
Nose bleeds		X
Prolonged bleeding		X

## AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
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.

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Patient / Legal Representative Signature

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Date

LINDA SheHON  
425-922-1887  
9/30/2020

Prescriptions - Losartan Potassium 100mg - 1x day  
Hydrochlorothiazide 25mg - 1x day

Supplements - VIT C - 1000 mg /day  
B<sub>12</sub> - 1000 mcg /2/day  
Super B complex 1/day  
CoQ10 300 mcg /day  
D<sub>3</sub> 125 mcg /day  
Baby ASPIRIN 81 mg /day  
Apple cider Vinegar 600 mg - 4 per day  
Mature Multivitamin 1/day  
Tumeric FORTE 117mg tumeric 2 /day  
HAIR Revitalizing complex 2x day  
Magnesium Citrate 250mg /day  
Calcium Citrate w/  
Magnesium - 80mg ZINC > 2/day  
Glucosamine w/  
MSM 1500mg > 2 /day  
1500mg  
Resveratrol - 75 mg 1 /day  
& Grapeseed - 235 mg  
Flaxseed oil w/  
omega 3 - 1400mg > 1 /day  
700 mg  
Lutein + Zeaxanthin - VISION complex > 1 /day alternating  
Preservision AREDS 2 (Bausch+Lomb)