



PERSONAL HISTORY INTAKE INFORMATION

Name (First, MI, Last): KEVIN A CORBETT

Date of Birth: 08 / 28 / 1959 Today's Date: 9 / 14 / 2020 Age: 61

Marital Status: MARRIED Level of Education: MASTERS

Occupation: Education Retired? Yes No

~~for my~~ Your Primary Care Provider:

Name: DR VATHEUER Phone: N/A

Date of Last Physical: 1 / 12 / 2019

Active Medical Problems:

NONE

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

NONE

Allergies – Drugs:

Allergies – Foods & Other:

NONE

Nutrients/Supplements you are currently taking & current amount:

C

ZINC

A

MULTI



PATIENT GOAL SHEET

Please rank your top 10 health goals. 1 being the highest priority and 10 being the lowest priority using each number only once.

4 Lose Weight/Fat

3 Increase Strength/Muscle

 Improve Libido/Sexual Function

 Improve Blood Sugar

 Improve Skin Appearance/Wrinkles

 Lower Blood Pressure

 Reduce Alopecia/Hair loss

 Improve Cholesterol Levels

 Treat Menopausal Symptoms

5 Improve Mental Function

 Improve Fatigue

2 Lower Dementia Risk

 Lower Cancer Risk

 Improve Sleep

 Decrease Pain

 Balance Hormones

6 Increase Energy/Stamina

 Increase Bone Density

 Treat Depression

7 Lower Cardiovascular Risk

 Reduce Inflammation

Other areas of your health you would like to improve:

Patient Name: Kevin A Corbett**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 / ~~TA~~ RCVS
- 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	83	GOOD		
Mother	84	EXCELLENT		
Brother(s)	52	EXCELLENT		
Sister(s)	56	EXCELLENT		

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

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	2018	ROUTINE PHYSICAL	
Ultrasound			
CT Scan			
MRI			
Bone Density (DEXA)	2018	INTEREST	
Other			

HEALTH HABITS

Which substances do you consume?

Substance	How Much?	
Caffeine NONE	cups, cans/day	/
Cigarettes NONE	packs/day	/
Are you interested in quitting? Or have you quit? Y / N	When did you quit?	N/A
Alcohol	Type WINE	Amount 2-4 GLASSES / WEEK
Drugs	Type	Amount
Chew Tobacco NONE	Amount	/
Nutrasweet NONE	Servings per day:	/
Saccharin NONE	Servings per day:	/
Splenda NONE	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? _____

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 _____ /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: 180 Date: 2015
6. As an adult my highest weight has been/is: 240+ Date: TODAY
7. What type of weight loss plan worked best for you in the past? EXERCISE, DIET
8. Your current weight: 240+ Goal weight: < 200

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

- How much sleep do you get at night (on average)? 7 Hours
- My usual bed time is: ~11 am/pm
- My usual wake time is: ~6 am/pm
- Approximate time before falling asleep is: < 2 minutes
- Do you awake in the night? No How many times? _____ Why? _____

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.	HAVE HAD	<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? SITTING ALL DAY & COMPUTER

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

6. If yes, please explain: COVID-RELATED SHUTDOWNS

Please complete if you are NOT currently exercising.

1. What prevents you from exercising?

Time Interest Energy Injury Motivation COVID SHUTDOWNS

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	4	<input checked="" type="radio"/> 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	<input checked="" type="radio"/> 4	5
I recognize that this is a long-term process, not a quick fix.	1	2	3	<input checked="" type="radio"/> 4	5

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

Adrenal	Yes	No	Cardiovascular/Respiratory	Yes	No
Fainting/collapse		✓	Chest pain		✓
Palpitations		✓	Blood in sputum		✓
Salt craving		✓	Unusual cough		✓
Muscle tension		✓	Shortness of breath		✓
Easily frustrated		✓	Swollen Ankles		✓
Sweat easily – palms/armpits		✓	Rapid heart beat		✓
Sugar craving		✓	Leg pain with walking		✓
Panic attacks		✓	Snoring excessively		✓
Feeling overwhelmed		✓	Fainting/collapse		✓
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		✓			
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		✓

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: KEVIN A CORBETT
 Address: 13036 109 Av NE KIRKLAND, WA 98034
 SSN: _____ Date of Birth: 08-28-1959
 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.

Patient / Legal Representative Signature

Date