LONGEVITY MEDICAL CLINIC™

Feel Younger · Live Better

PATIENT GOAL SHEET

Place a number from 1-10 with 1 being the highest priority and 10 being the lowest priority on which area you would like to work on.

____ Lose Weight

3 Increase Strength/Muscle

____ Improve Libido/Sexual Function

____ Lower Diabetic Risk

9 Improve Diabetes Control

____ Lower Blood Pressure

____ Improve Cholesterol Levels

6 Treat Menopausal Symptoms

7 Improve Mental Function

____ Improve Fatigue

1 Lower Dementia Risk

2 Lower Cancer Risk

____ Improve Sleep

____ Decrease Pain

____ Balance Hormones

5 Increase Energy

____ Increase Stamina

8 Improve Memory

4 Increase Bone Density

____ Improve Skin Appearance

Other areas of your health you would like to improve: Acid Reflux symptoms

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

Year	Procedure	Reason	Outcome
1978	Total Abd hysterectomy		good
1989	Hip replacement		good

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
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Fibromyalgia
- ☑ Depression
- ☐ Dermatomyositis
- ☐ Diabetes – Type I
- ☐ Diabetes – Type II
- ☐ 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			51	unknown
Mother			83	N/A
Brother(s)			22	MVA
			55	suicide
			78	unknown
Sister(s)			65	COPD
			76	unknown

Disease	Relation
Arthritis/Gout	
Asthma/Hay Fever	
Cancer (type):	Sister Breast
Drugs/Alcohol	
Diabetes	Brother
Heart Disease	
High Blood Pressure	Mother
Osteoporosis	
Stroke	

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

Test	Date	Reason	Result
Chest X-Ray			
EKG	Sept 2018		good
EGD (Stomach)	2016		good
Colonoscopy	2016		good
Ultrasound			
CT Scan			
MRI			
Bone Density (DEXA)	2015		Improved density
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?
Alcohol None	Type Amount
Drugs None	Type Amount
Chew Tobacco None	Amount
Nutrasweet None	Servings per day:
Saccharin None	Servings per day:
Splenda When eating out - Rarely	Servings per day:
MSG None	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.*

NA

- ☐ 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

If you currently have any of these symptoms, please 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
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- ☐ Vaginal Dryness/Pain
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Date of 1st day of last period Hysterectomy 1978 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:_____ Normal / Abnormal

Review this list of symptoms and check any that apply.

NA

- ☐ 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: None
   ☐ After meals ☐ Through morning ☐ Through afternoon ☐ Evenings ☐ No specific time

6. I tend to overeat:
   ☑ Never ☐ Seldom ☐ Often

7. I drink 3000 ML 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? None
   ☐ < 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: 108 Date:_____

6. As an adult my highest weight has been/is: 116 Date:_____

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

8. Your current weight: 110 Goal weight:_____

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

1. How much sleep do you get at night (on average)? 7 Hours
2. My usual bed time is: 2300 am/pm
3. My usual wake time is: 0600 am/pm ?
4. Approximate time before falling asleep is: ? minutes
5. 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.		✓
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? 1 hr 25 minutes
4. What motivates you to exercise? helps w depression
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	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?

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 OCD	✓	
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		✓

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		✓

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		✓
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	✓	
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		✓

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AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: Carolyn Jean Michels
Address: 281 Willsteen St, Leavenworth, 98826
SSN: ___-___-___ Date of Birth: 1/28/45
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.

Carolyn J Michels — 11/14/18

Patient / Legal Representative Signature — Date