

# LONGEVITY MEDICAL CLINIC

Feel Younger · Live Better

## PERSONAL HISTORY INTAKE INFORMATION

Name (First, MI, Last): Kathy T. Wilson

Date of Birth: 03/17/1956 Today's Date: 09/21/2020 Age: 64

Marital Status: Divorced Level of Education: Bachelors / Certificate

Occupation: Court reporter Retired?  Yes  No

Your Primary Care Provider:

Name: Katie Thilo (Kaiser) Phone: 253.383.6120

Date of Last Physical: 09/1/2019

Active Medical Problems:

Osteoporosis - compression fractures

back pain

Rosacea

Hormones

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

Prolia (twice a year)

Metronidazole cream (Razac) (.75%)

Globetassol Propionate Cream USP (.05%)

Rizatriptan (10 mg) use rarely, doesn't work sometimes

Ibuprofen rarely

Allergies - Drugs:

Penicillin

Allergies - Foods & Other:

some 50 mg, some 125

Nutrients/Supplements you are currently taking & current amount:

Vit B Complex - All about 25 mg

Magnesium - 800 mg

probiotic - 7 Billion

Cal/Mag/Zinc - 500 mg/80 mg/16 mg

Vit D - 5000 daily

Move Free - 3.3 mg

Glucosamine - 1500 mg - Hyaluronic

Chondroitin - 2000 mg

multi-Basic

Fish Oil - 25

Boswellia/Curcumin - 300 mg/300 mg

Baby Aspirin

Collagen - 12-15 g.

Bromelain - 100 mg (2x a week)

Zinc - 30 mg (3x a week)

1500-5000 mg (2x a week)

## 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.

Lose Weight/Fat

Lower Dementia Risk

7  Increase Strength/Muscle

10  Lower Cancer Risk

Improve Libido/Sexual Function

3  Improve Sleep

Improve Blood Sugar

2  Decrease Pain (migraines)

Improve Skin Appearance/Wrinkles

5  Balance Hormones

Lower Blood Pressure

8  Increase Energy/Stamina

Reduce Alopecia/Hair loss

4  Increase Bone Density

Improve Cholesterol Levels

1  Anxiety/OCD  
Treat Depression

Treat Menopausal Symptoms

Lower Cardiovascular Risk

9  Improve Mental Function

6  Reduce Inflammation

Improve Fatigue

Other areas of your health you would like to improve:

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Patient Name: Kathy Wilson

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

Year	Procedure	Reason	Outcome
1971?	Imperforate hymen		fixed
1987	jaw advancement	overbite	perfect bite
1985	delivery	birth of son	
2018	removal of staph	staph in my skull	no more staph after 8 week of infusion antibiotics

### 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 checked="" 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 checked="" type="checkbox"/> Anorexia/Bulimia              | <input type="checkbox"/> Heart Disease: Type: _____                  | <input type="checkbox"/> Pneumonia                   |
| <input checked="" type="checkbox"/> Arthritis: Type: <u>Osteo</u> | <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 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                   |
| <input checked="" type="checkbox"/> Candida / Yeast (teens)       | <input type="checkbox"/> Jaundice                                    | <input type="checkbox"/> Sjogrens                    |
| <input type="checkbox"/> Chronic Fatigue                          | <input type="checkbox"/> Kidney Disorder                             | <input type="checkbox"/> Stroke / TIA                |
| <input type="checkbox"/> Colitis: Type:                           | <input type="checkbox"/> Kidney Stones                               | <input type="checkbox"/> Thyroid problem             |
| <input type="checkbox"/> Coronary Artery Disease                  | <input type="checkbox"/> Liver Disease                               | <input checked="" type="checkbox"/> Root canal (1)   |
| <input type="checkbox"/> Crohn's Disease                          | <input type="checkbox"/> Lupus                                       | <input type="checkbox"/> TMJ                         |
| <input type="checkbox"/> Depression                               | <input checked="" type="checkbox"/> Migraines                        | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Dermatomyositis                          | <input type="checkbox"/> Multiple Sclerosis                          | <input type="checkbox"/> Urinary Infection           |
| <input type="checkbox"/> Diabetes – Type I                        | <input type="checkbox"/> Myocardial Infarction, past or asymptomatic | <input type="checkbox"/> Psychiatric hospitalization |
|   | <input type="checkbox"/> Myocardial Infarction symptomatic           | <input checked="" type="checkbox"/> Other: anxiety   |
|   | <input checked="" 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			89	aspiration pneumonia
Mother			80	peritoneal cancer
Brother(s)				
Sister(s)	62	great		

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

## RECENT TESTS

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

Test	Date	Reason	Result
Chest X-Ray	? 5 yrs.	pneumonia	no pneumonia
EKG	2017	fainted / did one in ER	negative
EGD (Stomach)			
Colonoscopy	2016	routine	3 polyps removed
Ultrasound			
CT Scan	2017	also after fainting	
MRI	Lots	brain, neck, spine, hips	
Bone Density (DEXA)	last 1/2019	Osteoporosis check	not much better
Other			

## HEALTH HABITS

Which substances do you consume?

Substance	How Much?	
Caffeine	cups, cans/day	
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.

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Acne                          | <input type="checkbox"/> Increased fat around hips/thighs   | <input type="checkbox"/> Painful sex               |
| <input type="checkbox"/> Bloating late in cycle                   | <input checked="" type="checkbox"/> Lack of periods         | <input type="checkbox"/> PMS ( ____ days)          |
| <input checked="" type="checkbox"/> Cravings for sugar, chocolate | <input type="checkbox"/> Leak Urine                         | <input type="checkbox"/> Polycystic Ovaries        |
| <input checked="" type="checkbox"/> Cramps/clots with periods     | <input checked="" type="checkbox"/> Loss of interest in sex | <input type="checkbox"/> Problems with Infertility |
| <input type="checkbox"/> Endometriosis                            | <input type="checkbox"/> Migraines late in cycle            | <input type="checkbox"/> Spotting after menopause  |
| <input checked="" type="checkbox"/> Facial hair                   | <input checked="" 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 type="checkbox"/> Vaginal Dryness/Pain      |
| <input checked="" type="checkbox"/> Irregular periods             |   | <input type="checkbox"/> Vaginal irritation        |

Date of 1st day of last period \_\_\_\_\_ Birth control method: \_\_\_\_\_ Are you pregnant? Yes/No

Date of last Pap test 2 years ago  Normal/Abnormal

Date of last Mammogram last year  Normal/Abnormal

Date of Menopause no clue Have you ever had an abnormal pap? Yes/No  When? \_\_\_\_\_

What hormones have you used in the past? compounded cream for last 10 yrs.

Any problems with these hormones? just recently (short time on pill form)

## 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 70 oz of water per day.  
 Tap     Well     Bottled     Distilled     Filtered

## WEIGHT LOSS

*Shouldn't be concerned, but am*

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: 85 Date: 1990?
  
6. As an adult my highest weight has been/is: 160 Date: 1979?
  
7. What type of weight loss plan worked best for you in the past? \_\_\_\_\_
  
8. Your current weight: 103 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				X							
Home				X							
Financial			X								
Work			X								
Relationship with:											
Illness				X							
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?		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)? \_\_\_\_\_ Hours

2. My usual bed time is: 11 am/pm

3. My usual wake time is: 5:30 am/pm

4. Approximate time before falling asleep is: 5 minutes

5. Do you awake in the night? yes How many times? 2 Why? peo

6. Check yes or no:

Yes No

I usually need an alarm to wake up.	<input checked="" type="checkbox"/>	X
My sleep is not restful.	<input checked="" type="checkbox"/>	X Sometimes
I have difficulty falling asleep.	<input checked="" type="checkbox"/>	X
I wake at night feeling like I am choking, being smothered or kicking my legs.	<input checked="" type="checkbox"/>	X
My partner notices I snore heavily.	<input type="checkbox"/>	
My partner notices I stop breathing through the night along with my snoring.	<input type="checkbox"/>	
I have restless legs that disturb my evening or sleep.	<input checked="" type="checkbox"/>	X
I wake at night and it is difficult to go back to sleep.	<input checked="" type="checkbox"/>	X Sometimes
I wake at night hungry or thinking of food.	<input checked="" type="checkbox"/>	X
I have daytime drowsiness or sleepiness.	<input checked="" type="checkbox"/>	X
If I am not active during the day I tend to fall asleep. (meetings, driving, etc.)	<input checked="" type="checkbox"/>	X
I am a night shift worker.	<input checked="" type="checkbox"/>	X
I have or might have sleep apnea.	<input checked="" type="checkbox"/>	X

## EXERCISE

Complete ONLY if you are currently exercising.

1. Exercise (s) you participate in:

Aerobic     Weights     Walking     Swimming     Bicycling     Running

Other: Pilates, stretch

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? 60 minutes

4. What motivates you to exercise? I like to move, feel better after, so I don't have guilt when I eat

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

(3)

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)

## DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

### Adrenal

Yes      No

Fainting/collapse	X
Palpitations	X
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

### 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
Fainting/collapse	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

### 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 unhealthy nails	X
Fibromyalgia	X
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

### Urinary

Yes      No

Blood in urine	X
Urgent urination	X
Frequent urination	X

### Hypersensitivity

Yes      No

Symptoms are year-round	X
Symptoms are seasonal	X
Recurrent canker sores	X
Diarrhea alt. with constipation	X
Dandruff/itchy scalp	X
Eczema/Dermatitis	X
Dizziness	X
Wheezing	X
Chronic cough	a little
Sinus congestion	X
Nasal congestion	X
Excessive mucus	X

### Metabolism

Yes      No

Excessive Thirst	X
Cannot skip meals	X
Headache if meal is missed	sometimes
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	a little
Alt. bet. sluggish/high energy	X
High blood pressure	X
Skin tags at neck/armpits	X
High cholesterol/triglycerides	X
Increased fat around abdomen	X
Prone to inflammation	?

### 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	not sure
Balance deteriorating	X
Coordination deteriorating	X
Change in headaches	X
Double vision	X
Dizzy/spinning	X

### Immune System

Yes      No

Frequent colds or flu	X
Rash across face and cheeks rosacea	X
Patchy red rash on body	X
Arthritis in fingers/hands	?
Asthma/Wheezing	X
Patchy hair loss	X

### Other

Yes      No

Unusual bruising	X
Nose bleeds	X
Prolonged bleeding	X



## AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: Kathy Wilson  
Address: 1462 Rainier Dr. #1, Fircrest, WA, 98466  
SSN: 538 - 68 - 0899 Date of Birth: 3-17-1956  
Name of Clinic or Physician: Kaiser Holistic Health Clinic  
Address: MLK Jr. Way-Tac. 19th & Union-Tac.  
Phone: 253.383.6120 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.

Kathy Wilson

Patient / Legal Representative Signature

10/14/2020

Date