MD LONGEVITY

CLIENT CONTACT INFORMATION

First Name: _____ MI: _____ Last Name_____

Billing Address: Street: _____

City: _____ State: _____ Zip Code: _____

Shipping Address (if different from billing address):

Street: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Please check your contact preference.

☐ Home: _____ ☐ Work: _____

☐ Cellular: _____ ☐ **Email:** _____

☐ Pager: _____ ☐ Fax: _____

____Private Fax ___Public Fax

Date of Birth: Gender:

Month: _____ Day: _____ Year: 19_____ ☐ Male ☐ Female

Emergency Contact:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relationship: _____

Whom may we thank for referring you? _____

What are your favorite hobbies/interests? _____

_____

MD LONGEVITY

CONFIDENTIAL HEALTH HISTORY

Today's Date: _____

NAME: _____ **Birth date :** ___/____/____ **Age:** _____

Marital Status: _____ **Level of Education**: _____
Current Occupation: _____ **Is your occupation enjoyable?** *Y / N*
Is it stressful? *Y / N* **Is it fulfilling?** *Y / N* **Hazardous Material exposure?** *Y / N*

If retired, what was your main occupation? _____
When did you retire? _____ **Are you happy in retirement?** Y / N

YOUR GOALS: *What you hope to achieve in your participation in the MD Longevity Program?*

_____
_____
_____

PLEASE LIST ACTIVE MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRESCRIPTION & OVER the COUNTER medications you are currently taking:

_____
_____
_____
_____
_____
_____

ALLERGIES: - DRUGS: **FOODS:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NUTRIENTS / SUPPLEMENTS you are taking:

_____
_____
_____
_____
_____
_____

CONDITIONS: *Check <u>any other</u> conditions you have ever had in the past, & indicate what year?*

___ AIDS / HIV+	___ Allergies / Asthma	___ Anemia	___ Alcohol / drug problem
___ Anorexia / Bulemia	___ Arthritis	___ Atrial Fibrillation	___ Anxiety / Panic Disorder
___ Back pain	___ Bleeding Disorder	___ Candida / Yeast	___ Cancer – Specify: _____
___ Chronic Fatigue	___ Crohn's Disease	___ Colitis	___ Diabetes -Type: I II
___ Depression	___ Emphysema	___ Epilepsy / Seizures	___ Fibromyalgia
___ Glaucoma	___ Goiter	___ Gout	___ Hiatal Hernia / Reflux
___ Heart Disease	___ High cholesterol	___ Irritable Bowel	___ Hypertension / High BP
___ Jaundice	___ Kidney Disorder	___ Kidney Stones	___ Liver Disease
___ Hepatitis	___ Migraines	___ Multiple Sclerosis	___ Osteoporosis
___ Pancreatitis	___ Parasites	___ Parkinson's	___ Pelvic Infl Disease
___ Pneumonia	___ Polio	___ Prostate Problem	___ Rheumatic Fever
___ Root canal	___ Sinusitis	___ Stroke / TIA	___ Suicide Attempt
___ Thyroid problem	___ TMJ	___ Tooth Abscess	___ Tuberculosis
___ Ulcers	___ Urinary Infection	<u>OTHER:</u> _____	
		_____	

CURRENT or RECENT SYMPTOMS: *Check any symptoms that you have noticed recently.*

___ Chest pain ___ Blood in sputum ___ Fainting / collapse ___ Leg pain w walking

___ Nose bleeds
___ Abdominal Pain
___ Difficulty swallowing
___ Kidney pain
___ Change in headaches
___ Bone pain
___ Excessive thirst
___ Recent change in bowel habit
___ Weight loss - unexpected
___ Shortness of Breath
___ Acid reflux
___ Loss of appetite
___ Blood in urine
___ Double vision
___ Unusual bruising
___ Rapid heart beat
___ Swollen ankles
___ Black tarry stools
___ Persistent nausea
___ Frequency of urination
___ Dizzy / spinning
___ Prolonged bleeding
___ Snoring excessively
___ Bright blood in stool
___ Mood swings
___ Urgency of urination
___ Eye pain
___ Bloated
Other Symptoms:_____
_____
_____

HOSPITALIZATIONS: *Please include Surgeries, illnesses, severe accidents, births, miscarriages:*

Year:	Procedure	Reason:	Outcome:

FAMILY HISTORY: *Please complete health Information about your family:*

Relation	Age:	State of health:	Age at Death:	Cause of death	Check if your blood relatives had any of the following √	Disease:	Relation to you:
Father						Arthritis / Gout	
Mother						Asthma / Hay Fever	
Brothers						Cancer: Where: _____	
						Drugs / Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Osteoporosis	
						Stroke	
						Tuberculosis	

RECENT TESTS:
If you have had any of these tests, please complete:

TEST:	Dat	Reason:	Result:
Chest X Ray			
EKG			
EGD (Stomach			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			
Other			

HEALTH HABITS:
***Which substances do you consume*:**

Substance	How Much?
Caffeine	**cups,cans**
Cigarettes	**packs / day x**
Are you interested in quitting? Y / N	
Alcohol	**Type Amount**
Drugs Y N	**What Amount**
Chew tobacco Y N	**Amount Yrs**
Nutrasweet	Servings per day:
Saccharin	Servings per day:

FOR WOMEN:

Date of 1st day of last period: _____ Birth control method: _____ Are you pregnant? Y / N

Date of last PAP test: _____ *normal / abnormal* Date of last Mammogram: _____ *normal / abnormal*

Date of Menopause: _____ Have you ever had an abnormal pap? Y / N When? _____

Review this list of symptoms and check the ones that apply.

___ PMS
___ Uterine Fibroid
___ Fibro-cystic Breasts
___ Ovarian Cysts
___ Irregular periods
___ Vaginal irritation
___ Increased fat around hips / thighs
___ Hot flashes
___ Vaginal Dryness / Pain
___ Loss of interest in sex
___ Leak Urine
___ Painful periods
___ Painful sex
___ Endometriosis
___ Sleep problems
___ Mood swings
___ Painful Periods
___ Unusual vaginal discharge
___ Cramps / clots w periods
___ Spotting after menopause
___ Problems w Infertility

FOR MEN:

Date of last prostate exam: _____ *normal / abnormal*

Review this list of symptoms and check the ones that apply:

.___ Lowered interest in sex __ Erections less firm___ Difficulty in initiating urine stream __ Getting up at nite to urinate ___ Enlarged prostate __ Can't maintain an erection__ Slowing urinary stream___ Problems w Infertility __ Bladder not emptying completely

REVIEW THESE SYMPTOMS OF AGING AND CHECK THE ONES THAT APPLY.

Thyroid

___ Dry hair
___ Infertility
___ Migraines
___ Losing hair
___ Constipation
___ Fluid retention
___ Crave caffeine
___ Dry coarse skin
___ Diets don't work
___ Cold hands & feet
___ Elevated cholesterol
___ Low body temperature
___ Fatigue / Exhaustion
___ Decreased memory
___ Brittle unhealthy nails
___ Unable to lose weight
___ Daytime drowsiness
___ Foggy / spacey mind
___ Depression / Anxiety
___ Low ambition / motivation
___ Decreased concentration
___ Fibromyalgia / Chronic fatigue
___ Feel cold / dress more warmly

Cardio-Respiratory:

___ Palpitations
___ Decreased stamina
___ Decreased endurance
___ Run out of breath sooner
___ Easily exhausted with exercise
___ Decreased ability and desire for exercise

Adrenal:

___ Palpitations
___ Salt craving
___ Sugar craving
___ Panic attacks
___ Muscle tension
___ Easily frustrated
___ Excessive hunger
___ Prone to infection
___ Low blood pressure
___ Poor stress tolerance
___ Low back pain (SI joints)
___ Light headed on standing up
___ Racing mind prevents sleep
___ Need sunglasses in bright sun light

Metabolism:

___ Can not skip meals
___ High blood pressure
___ Headache w missed meal
___ Cravings for sugar & carbs
___ High cholesterol / triglyceride
___ Increased fat around abdomen
___ Prone to inflammation and bursitis
___ Periods of low energy relieved w food
___ Shaky / weak episodes – Eating helps
___ Jittery / irritable episodes – Eating helps
___ Alternating between high and low moods
___ Alternating between sluggish and high energy

Skin / Integumentary:

___ Dry skin
___ Thin Lips
___ Graying hair
___ Skin blemishes
___ Thin brittle nails
___ Tendency to bruising
___ Thinned skin –hands, face, arms
___ Thinning hair – scalp, armpits, legs
___ Wrinkling skin – face, neck, hands & arms
___ Sagging skin – under eyes, arms, face, breasts

Neuro-cognitive:

___ Loss of esteem
___ Feeling hopeless
___ Feeling defeated
___ Loss of confidence
___ Vision deteriorating
___ Hearing deteriorating
___ Memory deteriorating
___ Sense of powerlessness
___ Decreased sense of well being

Gastrointestinal:

___ Feel full faster
___ Slower digestion
___ Fullness after meals
___ Eat less / smaller meals
___ Indigestion / Hyperacidity
___ Burping or belching after meals
___ Decreased sense of taste / smell

Muscles/Joints:

___ Osteoporosis
___ Aches and Pains
___ Loss of strength
___ Body & joints stiff
___ Balance deteriorating
___ Coordination deteriorating
___ Thinning muscles – buttocks, arms, legs

DIET: **Are you on any specific diet?** *(Please specify:*_____ Successful? Y / N
List which diets have been effective in the past: _____

STRESS:
Rate your current stress level: *Extreme;* *High;* *Medium;* *Low* *(Please circle)*
How long has it been like this? _____
You expect this to last a *short* *medium* *long* period of time. *(please circle)*
Do you have a solution? Y / N
Do you need help? Y / N

EXERCISE: *Please circle which you do.*
Aerobic Weights Walking Other:_____
How long are your workout sessions? _____

How many days / week? _____

SLEEP: *Please check the symptoms that you notice.*
___ Trouble getting to sleep – racing mind
___ Sleep not as restful / Wake up not rested
___ Wake up through night feeling like you are choking or having a smothered sensation
___ Your partner has noticed very heavy snoring during sleep
___ Your partner has noticed that you stop breathing through the night with heavy snoring
___ Daytime drowsiness or sleepiness especially with periods of inactivity
___ Toss and turn through night / wake frequently through night

Take a moment to reflect on your response to the following question:
On a scale of 0 – 5 (5 being the strongest response), circle your response:

How important and committed are you to a longevity program? 0 1 2 3 4 5