



*Self Administered Evaluation Form*

Thank you for taking the time to fill this form, and it will aid the physician in determining your preventive therapeutic plan for optimal aging.

<b>Your name</b>
Chronological Age
Address
Phone
Fax
E-mail

What are your personal goals for this program? (Please describe)

<b>Disease prevention &amp; longevity</b>
Hormonal assessments for andropause & treatments
Hormonal assessments for menopause & treatments
Memory & cognitive assessments & treatments
Osteoporosis & joints assessments & treatments
Cardiovascular health assessments & treatments

Oxidative stress (Vitamin use) assessments & treatments
Sexual Dysfunction assessments & treatments
Cholesterol, blood pressure, diabetes screenings & treatments
Weight loss & nutritional programs
Exercise counseling & tailored programs

Are there any other issues that you want us to address?

(Please note that we may have to refer you to other specialists, if the problem falls outside our scope)


Please tell us more about yourself:

Do you smoke, and how much?
Do you drink, and how much?
Have you done drugs before?
What do you think is your ideal body weight?
How often do you <i>exercise</i> in a week?
Please describe your exercise routine
What kind of work do you do?

Are you allergic to any drugs? Yes  No

Name of drug:

Current prescription medications:

Current vitamins & supplements & dosage:

Tell us about your past medical history:

- High Blood Pressure Yes  No
- Diabetes Yes  No
- High Cholesterol Yes  No
- Heart Attack Yes  No
- Surgery Yes  No
- Hospitalizations: Yes  No
- Clinical Depression: Yes  No

Describe: \_\_\_\_\_

For Women:

Menstrual history, Menopause, Children, Contraception, Mammogram, PAP smear

For Men:

Last prostate examination, self-testicular examination, erectile dysfunction problems

If you are a **male** over the age of 40 years, please also complete the St. Louis University Andropause (ADAM) Questionnaire

1. Do you have a decrease in libido? Yes  No

2. Do you have a lack of energy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3. Do you have a decrease in strength and/or endurance?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
4. Do you have a decreased enjoyment of life?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5. Are you sad?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
6. Are you grumpy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7. Are your erections less strong?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
8. Noticed a recent deterioration in your ability to play sports?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
9. Are you falling asleep earlier after dinner?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
10. Has there been a recent deterioration in your work performance?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you are **female** over the age of 40 years, please also answer the following OPAL Menopause questionnaire:

1. Change in the length, flow or frequency of your menstrual cycle?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2. Do you suffer from hot flashes?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3. Do you have night sweats & insomnia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
4. Do you have mood swings	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5. Do you have problems with your memory or concentration?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
6. Has sexual intercourse become uncomfortable because of dryness?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7. Have you lost interest in sexual activities or libido?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
8. Did your mother undergo menopause at the same age?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
9. Did you have a hysterectomy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
10. Are you opposed to hormonal replacement?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

We need to take a diet history of what you ate in the **past 3 days** prior to you filling this form:  
 (Please include portion size)

	Breakfast	Mid Morning	Lunch	Mid Afternoon	Dinner	After Dinner	Drinks: Sodas, Alcohol, etc.
Yesterday							
2 days ago							
3 days ago							

Please tell us about your **family longevity history**:

(Please answer as best as you can, and omit if you are unsure)

	Present Age	Age Died	Diabetes	Blood Pressure	Heart Disease	Cancer	Alzheimer's
<b>Father</b>							
Father's father							
Father's mother							
Father's brother 1							
Father's brother 2							
Father's sister 1							
Father's sister 2							
<b>Mother</b>							
Mother's father							
Mother's mother							
Mother's brother 1							
Mother's brother 2							
Mother's sister 1							
Mother's sister 2							