Healthy Living and Longevity Medical Center

Function Higher — Physically, Mentally, Sexually®

PATIENT NAME: _____ DATE: ____/___/____

NAME YOU WOULD LIKE TO BE CALLED: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

AGE: _____ DATE OF BIRTH: ____/___/_____ SOCIAL SECURITY #: _____

WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

FAX NUMBER: ( ) _____ HOME PHONE: ( ) _____

AT WHICH TELEPHONE NUMBER(S) MAY WE CONTACT YOU? _____

EMAIL ADDRESS: _____

OCCUPATION: _____

PHARMACY NAME & PHONE:( )_____ ( ) _____

HOW DID YOU HEAR ABOUT US? ☐FRIEND ☐NEWSPAPER ☐MAGAZINE ☐RADIO ☐TV ☐INTERNET ☐ OTHER (LIST) _____

OTHER MEDICAL COUNSEL (NAME AND TELEPHONE NUMBER IF YOU HAVE THIS FORMATION):

_____

_____

MAY WE CONTACT THIS/THESE PRACTITIONER(S)? ☐YES ☐ NO

_____

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MEDICAL HISTORY FORM

1. Are you ready to make changes in your life? Please indicate you level of readiness by circling the appropriate number in the scale below.

Not prepared to change	0 1 2 3 4 5 6 7 8 9 10	Already changing

2a. What would you like for me to help you improve during your visits? Rate them in order of importance for the top three, and then list the others.

2b._____

2c._____

2d._____

Other _____

_____

3. Current and chronic medical conditions not listed above, please list:

_____

_____

4a. Have you had any hospitalizations? ☐Yes ☐No

4b. Have you had any emergency room visits? ☐Yes ☐No

4c. Have you had any diagnostic procedures or surgery? ☐Yes ☐No

4d. Have you ever had head trauma (went unconscious), even mild head trauma (been stunned or had a concussion) as an adult or as a child? ☐Yes ☐No

4e. If Yes, please explain:_____

5. Family members diagnosed with cancer or other medical conditions (please specify):

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Grandparents: _____

PLEASE TELL US ABOUT YOUR PERSONAL SITUATION:

6. With whom do you live? _____

7. Are you employed? ☐Yes ☐No
If Yes, what kind of work do you currently do, and do you enjoy your work?
_____

8. How many children do you have? _____ Ages_____

9a. Do you smoke tobacco? ☐No ☐Yes. If yes, for how long_____ and how many packs a day___ week_____.

Tobacco use: ☐Cigar ☐Pipe ☐Snuff ☐Chew

9b. Have you quit? ☐Yes ☐No

9c. Are you interested in quitting? ☐Yes ☐No

10a How much caffeine do you consume per day?
☐Coffee or tea ___ cups ☐Sodas with caffeine ___ cans or bottles

☐Chocolate ___ ounces ☐None

10b. Are you interested in quitting? ☐Yes ☐No

11a. How much beer, wine, liquor do you consume per week?

☐Beer, ___glasses ☐Wine, ___glasses ☐Hard Liquor, ___ounces ☐None

11b. Does your drinking interfere with your daily functioning or relationships? ☐Yes ☐No

11c. Do you need a drink in the morning, 'an eye-opener'? ☐Yes ☐No

11d. Are you interested in quitting? ☐Yes ☐No

12a. Do you use recreational drugs? ☐Yes ☐No

12b. Have you ever used needles? ☐Yes ☐No

12c. Are you interested in quitting? ☐Yes ☐No

13a. Are you sexually active? ☐Yes ☐No ☐Not currently, how long _____

13b. Current sexual partner(s) is/are: ☐Male ☐Female ☐Both ☐None

13c. Do you have sexual energy? ☐Yes ☐ If not currently, for how long _____

13d. Do you use contraception? ☐Yes ☐No, If yes, what type _____

13e. Do you want to be tested for sexually transmitted diseases? ☐Yes ☐No

14. Do you exercise regularly? ☐Yes ☐No, for ____minutes per day.

What kind of exercise? _____

15. Do you wear seat belts consistently? ☐Yes ☐No

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16. Have you ever been abused? ☐Yes ☐No

If Yes, please explain: _____

_____

17. Is violence in the home a concern for you? ☐Yes ☐No

If Yes, please explain:_____

18. Any addictions,, i.e., gambling, sex, alcohol, tobacco? ☐Yes ☐No

19a. Please list the major Stressors/Issues in your life,

_____

_____

_____

19b. On a scale of **0-10**, how big a role does stress play in your life?

Circle the number below that best reflects the answer.

No stress	0 1 2 3 4 5 6 7 8 9 10	The most stress you can have

19c. Do you feel that you handle stress well? ☐Yes ☐No

19d. Do you feel “tired and wired”: unable to fall asleep? ☐Yes ☐No

19e. Are you feeling ‘wired’ or high strung? ☐Yes ☐No

19f. If zero (0) is NO LIFE SATISFACTION and ten (10) is ABOVE CONTENT, where would you rate yourself on the scale below. Put a check mark in the box below the appropriate number.

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No satisfaction	0 1 2 3 4 5 6 7 8 9 10	Above content

19g. Do you feel refreshed in the morning upon awakening? ☐Yes ☐No

19h. Do you feel “tired” all day? ☐Yes ☐No

19i. Rate your energy level if zero (0) is NO energy and ten (10) is THE MOST ENERGY YOU CAN HAVE:

No energy upon awakening	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

No energy at 11AM	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

No energy at 2-3 PM	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

No energy at 7PM	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

No energy at 10-11 PM	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

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No energy now	0 1 2 3 4 5 6 7 8 9 10	The most energy you can have

Time of day is (fill in and circle) _____ AM/PM

20a. What is the quality of your sleep (excellent, good, poor)?
Explain_____

20b. How many hours a night do you typically sleep? _____hours

20c. How many times a night do you wake up (and why)? _____

21. How much *filtered* water do you drink in one day? _____

22a. Do you have cravings for foods? ☐Yes ☐No

22b. If Yes, list which foods you crave:_____

22c. If so, when do the cravings occur? _____

23a. How many times a day do you move your bowels? _____

23b. I have regular bowel movements daily ☐yes ☐No

23c. Do you experience bloating, belching, burning, or gas *within one hour* after eating?
☐Yes ☐No

23d. Do you have constipation, diarrhea, or would you characterize your bowel movements as irregular in any way? ☐Yes ☐No

If Yes, please explain: _____

23e. Do you have weak, peeling, or cracking of the finger nails? ☐Yes ☐No

23f. Do you have food sensitivities, or allergies? ☐Yes ☐No

23g. Do you have itching around the rectum? ☐Yes ☐No

24a. Are you gaining weight even though you are watching what you eat? ☐Yes ☐No

24b. Do you consider that you eat 'healthy'? ☐Yes ☐No

24c. Recent weight gain _____pounds over the last year. On purpose? ☐Yes ☐No

24d. Recent weight loss _____pounds over the last year. On purpose? ☐Yes ☐No

24e. <u>Best recollection</u>

High school weight: _____

Present weight: _____

Desired weight: _____

Highest weight: _____

Height: _____

Clothing size: _____

How many times have you been on a weight loss diet? _____

25a. Did you become ill while or after traveling outside of the USA? ☐Yes ☐No

25b. List where and when: _____

_____

25c. Have you ever been treated for parasites? ☐Yes ☐No

26. Have you received a blood transfusion? ☐Yes ☐No

27. What are your hobbies? _____

28. Have you ever taken multiple courses of antibiotics? ☐Yes ☐No

29. Have you had psychological counsel in the past, or are you presently seeing someone?

    ☐Yes ☐No

    If Yes, please explain: _____

30. Do you know if you have you been exposed to environmental chemicals or toxic heavy metals? ☐Yes ☐No

    If Yes, which ones? _____

31a. How many dental visits do you have yearly? _____

31b. Do you regularly floss? ☐Yes ☐No How often? _____

31c. Do you have silver fillings (mercury amalgams)? ☐Yes ☐No

31d. Do you have any root canals? ☐Yes ☐No

32a. Age of first period: _____

32b. Are you having a monthly menstrual cycle? ☐Yes ☐No

32c. Length of average period: _____days

32d. Do you have concerns about your periods? ☐Yes ☐No

    If Yes, what are you concerned about _____

32e. Frequency of menstrual periods: Regular ☐Yes ☐No; and occur approximately every _____days.

32f. The first day of your last menstrual period was _____

33a. How many times have you been pregnant? _____

33b. Number of live births? _____

33c. Miscarriages: ☐Yes ☐No

33d. Number of C-sections: _____

33e. Are you currently pregnant or breast feeding? ☐Yes ☐No

33f. Do you currently use contraception (birth control pills, IUD, injections)? ☐Yes ☐No

34a. Do you have concerns about menopause? ☐Yes ☐No

34b. If Yes, what are you concerned about: _____

35a. Have you had a DEXA Scan (Bone Density Scan)? ☐Yes ☐No

35b. If Yes, when was it done, and what were the results? _____

36a. Last Pap smear normal? ☐Yes ☐No

36b. If abnormal, what was the result: _____

36c. Date of last Pap smear? _____

37. Have you had gynecologic surgery, and if so, what was done and when was it performed? _____

38a. Have your breasts been aspirated or have you had a breast biopsy? ☐Yes ☐No

38b. If Yes, what were the results: _____

38a. Was your last mammogram normal? ☐Yes ☐No

38b. Date of last Mammogram or other breast exams, and results: _____

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Allergies, Medicines, and Supplements

1a. Allergies to medicines, foods, and environmental substances (such as latex)?

☐Yes ☐No

1b. If Yes, please list each one and explain what happens when taken:

_____

_____

2. List all medications: including over-the-counter (for example: aspirin), herbal remedies, hormones (both natural and synthetic), vitamins, and mineral supplements, *and note strength and how often you take them* (attach extra paper to list all):

_____

_____

_____

_____

_____

_____

_____

_____

3. Are you willing to take supplements (vitamins, minerals, etc.)? ☐Yes ☐No

If Yes, how many supplements are you willing to take? ☐ 10 ☐ 25 ☐ or as many as Dr. Bieley prescribes?

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Directions:

Please take your time when filling out this part of the form. You do not have to complete it at one sitting. Only rate the severity of each that applies to you (even if it appears under multiple headings) as: **1 = MILD, 2 = MODERATE or 3 = SEVERE. Leave blank** if it does not apply to you.

Please be sure to complete each of the sections regardless of title**, such as PMS**. They are for educational purposes only. Even if you are have not had menses (menstrual periods) for years, please rate all of the signs and symptoms that you currently experience below.

PLEASE **do not use check marks** to answer. We wish to obtain an accurate baseline of the severity of your signs and symptoms, and to assess improvement during treatment.

Aldosterone Deficiency		
___ A drowsy, absent-minded look	___ Feel better (in your head) when laying flat on a bed, or moving around all of the time	___ Soft eye balls (eyes feel soft to pressure)
___ 'Crows feet' (wrinkles around outside of eyes)	___ Foggy look	___ Sunken eyes deep in orbits
___ Deep wrinkles on face	___ Hollow or pale face	___ Tendency to move around all the time when standing up
___ Deep grooves in hand creases	___ Low blood pressure	___ Thirsty often, and tendency to drinking a lot of fluids
___ Difficulty focusing on tasks	___ Salt and salty food craving	___ Tongue with teeth marks visible at tongue borders
___ Drowsiness, zombie-like feeling	___ Sharp eyelid fold above the eye	___ Troubled vision with difficulty focusing on objects and tasks when standing up
___ Easily distracted, absent-minded	___ Skin tenting- prolonged stiff skin fold after pinching the skin on the back of the hand	

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Adult-Onset Growth Hormone & IGF-1 Deficiency		
___ Abdominal obesity, fat belly	___ Flat feet, with collapsed arches	___ More pronounced wrinkling
___ Chronic anxiety without any reason	___ Flat appearing hair	___Nails with longitudinal lines
___ Cold intolerance	___ Feeling rapidly aging, feeling of profound physical degradation	___ Poor general health
___ Decreased muscle strength	___ Great difficulty in performing multiple tasks	___ Poor appetite for meat
___ Deep wrinkled forehead	___ Impaired emotional reactions	___ Recovering very difficult
___ Depression	___ Impaired emotional reactions	___ Receding gums and jaw bone
___ Difficulty recovering when not having slept enough	___ Impaired psychological well-being and quality of life, lacking inner peace	___ Reduced aerobic and anaerobic capacity (easily tire)
___ Dramatizing: outbursts of panic and anxiety; may collapse from minor stress	___ Impaired social status (lower professional position, lower income, poor social integration, often without partner, still living with parents)	___ Reduced muscle and strength
___ Dropping of eye lids (upper or lower lids)	___ Inability to lose weight with diet and exercise	___ Resistant to new ideas and situations
___ Droopy triceps (lower arm muscles sagging) or other muscles (like draperies hanging)	___ Intensified jet lag effect	___ Sagging of body silhouette: sagging cheeks, sagging belly or sagging buttocks
___ Droopy nose tip	___ Kyphosis (bowed back, stooped over)	___ Smaller shoulders, dropping triceps, wrinkled hands, small hips, sagging inner sides of thigh

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___ Dry skin	___ Lack of concentration	___Sore feet after long walks
___ Excessive emotional reactions, sharp verbal retorts	___ Lack of inner peace	___ Stretch marks on thighs
___ Excessive need for sleep	___ Lack of self confidence, assurance, leadership (afraid of what today will bring)	___ Tendency to be depressed
___ Exhausted, especially	___ Less self control	___ Tendency toward social Isolation
after midnight	___ Less vitality or energy	___ Thick thighs with cellulite
___ Exhausted with poor or no recovery	___ Light sleep	___ Thinning of eyebrows
___ Eye brow thinning	___ Loose skin folds under the chin	___ Thinning of lips
___ Fatty buttocks	___ Loss of skin tone	___ Tiny, fine skin folds (more apparent with finger pressure)
___ Fatty thighs	___ Low self esteem	___ Thinning of skin with hair loss (tiny fine skin folds)
___ Fatty cushions above the knees	___ More body fat with skin thinning and muscle weakness, flabby belly	___Thinning nose with the tip pointing downward

Calcitonin Deficiency		
___ Greater pain sensitivity	___ History of trauma to thyroid gland with sudden onset of symptoms (from one day to the next)	___ Tired
___ Greater predisposition to pain	___ Brittle bones (Osteoporosis)	___ Nausea or vomiting
___ bowed back, hunched appearance	___ Stress that triggers migraine headaches	___ Lack of appetite
___ Crushed spine	___ Pain in the neck, or back	___ Feeling unwell

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___ Bulging disc(s) in spine	___ Nervous tension	___ Dizziness
___ Scar from surgery for removal of thyroid (check only for Yes).	___ Muscle aches	___ Headaches
___ History of thyroid irradiation (check only for Yes)	___ Low energy, fatigue	

Cortisol Deficiency		
___ Acute allergies: runny nose,	___ Frequent screaming or yelling	___ Recent hair loss in patches
___ Asthma, food allergies	___ Heavy sweating in armpits	___ Prone to infections: viral (flu, mono), bacterial (affecting ears, nose, & throat)
___ Brownish skin in armpit fold	___ History of gastroenteritis, bloating, or abdominal pain	___ Recurrent tendon pains, especially sensitive to pressure
___ Brown skin in elbow fold	___ Hollow cheeks	___ Salty food cravings
___ Brown skin folds in palms	___ Inflammatory diseases such as lupus or rheumatoid arthritis	___ Sharp verbal retorts, use of strong, dramatized words
___ Confusion, absentmindedness, especially in stressful situations	___ Intense hunger attacks	___ Skin rashes
___ Dark circles under eyes	___ Irritability	___ Sugar cravings
___ Day-dreaming, empty headedness	___ Localized muscle pains	___ Suntan easily
___ Depigmented skin areas (vitiligoligo)	___ Low energy, fatigue, burned out	___ Underweight, with difficulty gaining weight
___ Excessive compassion for the pain of others	___ Memory loss in stressful situations	___ Tired look
___ Excessive emotions: outbursts of anger or anxiety	___ Painful sinus points	___ Very negative attitudes

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___ Excessive sensitivity to human suffering	___ Paranoid-like reactions, accusatory behavior, quarrelsome	___ Wet palms
___ Feeling like being a 'victim'	___ Poor resistance to stress, or great difficulty to function well in stressful situations or even to react to stressful situations	___ Yellow-brownish skin of face

Cortisol Excess		
___ Binge eating	___ Frequent infections	___ Shakiness between meals
___ Confusion	___ Irritability	___ Thin skin
___ Cravings for sugar	___ Low energy	___ Weight gain
___ Easy bruising	___ Muscle weakness	
___ Fatigue	___ Night sweats	

Dehydroepiandrostenedione (DHEA) Deficiency		
___ Decrease in muscle strength and lean body mass	____ lack of sexual satisfaction	___ Poor quality of life and feeling of wellness
___ Dry eyes, or dry skin	___ Moderate anxiety	___ Poor sleep
___ Frequent infections	___ Moderate fatigue	___ Reduced or loss of pubic hair
___ Joint soreness	___ Overwhelming stress	___ Reduced pubic fat
___ Low resistance to noise or stress	___ Poorly developed or receding hair in armpits	
___ Low sexual desire	___ Poor muscle development	

Dysbiosis (Abnormal Function Due To Changes In Gut Bacteria)		
___ Abdominal pain	___ Fatigue	___ Nausea
___ Anxiety and depression	___ Fever of unknown origin	___ Palpitations (feeling your heart beat)

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___ Arthralgias (painful joints)	___ Flatulence (farting)	___ Phlebitis (inflamed veins)
___ Belching, bloating, burning (heartburn)	___ Frequent urination	___ Pruritis (itching)
___ Brain fog	___ Halitosis (bad breath)	___ Seizures
___ Cramps and spasms	___ Malaise (feeling no energy)	___ Skin rashes
___ Cognitive and memory deficit	___ Myalgias (muscle pains)	

Estrogen Deficiency		
___ Above upper lip small vertical wrinkles	___ Hairy arms	___ Persistent depression
___ Achy joints	___ Hot flashes with sweating (especially at night)	___ Persistent fatigue
___ Acne	___ Increased cholesterol	___ Recurrent bladder infections
___ Decreased dexterity	___ Increase in insulin resistance and possible diabetes (if you know)	___ Scalp hair flat in appearance
___ Decreased or poor memory	___ More wrinkles/ aging skin	___ Small breasts
___ Decreased sex drive	___ Oily skin	___ Small, sharp wrinkles above the upper lip and corners of the mouth
___ Droopy breasts	___ Osteoporosis (brittle bones over time	___ Thinner skin
___ Dry eyes, or mouth	___ Painful intercourse	___ Urinary incontinence (leaky bladder)
___ Dry skin	___ Painful menstrual cramps	___ Urinary tract infections
___ Excessively developed pubic hair	___ Pale face, or hollow face	___ Vaginal dryness
___ Facial hair	___ Painful menstrual cramps	___ Vaginal itching
___ Hair loss in scalp	___ Pale face, or hollow face	

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Estrogen Excess		
___ Aggressive, or irritable with outbursts of anger especially before menses (period)	___ Enlarged, swollen breasts with nipple tenderness	___ Painful breasts, particularly nipples when pressed
___ Anxious, nervous	___ Fatigue	___ Poor sleep
___ Anxious premenstrual syndrome	___ Fibrocystic breasts	___ Reddish face
___ Bloating (especially belly)	___ Increased weight (especially hips/thighs)	___ Sharp verbal retorts
___ Breasts enlarged and painful when pressed	___ Irritability	___ Swollen painful bloated belly
___ Cervical dysplasia (abnormal Pap smears)	___ Mood swings	___ Swollen thighs, legs, ankles or feet
___ Decreased sexual interest	___ Overweight or obese	
___ Depression with anxiety or agitation	___ Panic attacks	

Insulin Deficiency		
___ Apathy	___ Fatigue, general weakness	___ Low to normal glucose (if known)
___ Arms are underdeveloped or droopy arm muscles	___ Feet are thin and poorly muscle mass	___ Low to normal glycoslyated hemoglobin (HbA1C) (if known)
___ Belly too thin, flat	___ Hips and buttocks are narrow, thin hips and/or buttocks, lacking fat	___ Moments of low alertness, inattention
___ Breasts are sagging	___ Legs are thin, poor muscle mass	___ Neck is thin and poorly muscled

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___ Breasts have poor fat accumulation	___ Loss of fat mass	___ Sweets and sugars are not tolerated well
___ Chest poorly developed muscles	___ Low insulin (if known)	___ Thin, hollow face
___ Difficulty in receiving and giving love	___ Low libido	___ Underweight body and or extremely thin

Melatonin Deficiency		
___ A superficial, anxious, agitated sleep with a lot of anxious thinking	___ Frequent infections	___ Premature aging of the hands with age spots
___ Agitation with restless leg syndrome at night	___ Jet-lag symptoms when going to another time zone	___ Poor dreaming
___ Binge eating	___ Lack of serenity, inner peace of mind, especially at night	___ Shakiness between meals
___ Cravings for sugar	___ Looking tired, not having slept well (bags) under eyes)	___ Tendency to go to bed late and wake up early
___ Difficulty to fall asleep and fall back asleep	___ Low energy	___ Thin skin
___ Easily waking up during the night	___ Muscle weakness, or tense muscles, especially at night	___ Weight gain
___ Easy bruising	___ Nervous, anxious behavior	
___ Fatigue or irritability	___ Night sweats or sleep disturbances	

MSH (Melanocyte Stimulating Hormone) Deficiency		
___ Darker skin that became paler	___ Less vaginal lubrication	___ Muscle loosening

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___ Difficulties in vaginal opening for penis or sex toy insertion	___ Low or lower capacity for sexual intercourse	___ Overweight or obese due to progressively increased appetite and worsened in adult years
___ Face appears pale (in Caucasians)	___ Low or lower frequency and intensity of erotic fantasies	___ Paler hair
___ Flat,or non-curling hair. Lack of hair volume	___ Low or lower frequency and intensity of erotic fantasies	___ Poor memory
___ Gradually decreased ability to tan in the sun that was previously normal	___ Low or lower orgasmic capacity	___ Poor school performance
___ Gray or white hair	___ Low or lower sexual arousal, sex drive	___ Possible lower resistance to stress
___ Joint pains under stressful conditions	___ Low or lower skin sensitivity to sexual caress	___ Sunburned skin occurs easily
___ Less sexual arousal	___ Lower or lower sexual arousal, decreased sex drive	

Oxytocin Deficiency		
___ Absence of multiple orgasms	___ Joyless appearance, unhappy face	___ No emotional flush
___ Absence or rareness of orgasm	___ Less social involvement	___ No smile or smiles less
___ Circle of friends is decreasing	___ Limited emotional expression	___ Not warm-hearted
___ Dry eyes	___ Low or lower orgasmic intensity	___ Pale face
___ Easy pain perception	___ Mainly retains old friends, but very few, if any new friends	___ Poor lifeless gaze
___ Excess pain sensitivity	___ (If) Married, marriage less happy	___ Teamwork possible but less easy than before
___ Excessively (emotionally) detached from others	___ Needs 20 minutes or more to achieve orgasm	

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Pregnenolone Deficiency		
___ Abdomen is painful if pressed	___ Lack of mental firmness and aggressiveness	___ Small breasts
___ Decreased libido (sexual energy)	___ Moderate fatigue (chronic)	___ Soft eye balls (eyes feel soft to pressure)
___ Deficient muscle mass	___ Nervous behavior	___ Sugar cravings
___ Dry skin	___ Pigmented spots on face	___ Sunken eyes
___ Excessive thirst and drinking	___ Poor Memory, short term memory loss	___ Sweating hands and armpits during stress
___ Excessive urination	___ Poor muscle strength	___ Thin, hollow face
___ Feeling faint when standing up	___ Pubic hair thinning or poorly developed	___ Thin muscles
___ Foggy, absent-minded look	___ Reduced color vision	___ Unclear thinking
___ Forgetful behavior	___ Salt or sugar cravings	
___ Heart rate is quick (more than 80 beats/min)	___ Sharp wrinkles	

Premenstrual Syndrome (PMS)		
___ Abdominal bloating	___ Distractible	___ Panic attacks
___ Aches and pains	___ Dizziness	___ Pins and needles feeling
___ Acne	___ Drowsiness	___ Poor coordination
___ Alcohol sensitivity	___ Dry hair	___ Poor judgment
___ Angry outbursts	___ Eye pain	___ Poor memory
___ Anxiety	___ Facial swelling	___ Poor vision
___ Appetite changes especially lack of appetite	___ Fatigue	___ Rapid heart beat
___ Asthmatic attacks	___ Fear of going out alone	___ Restlessness
___ Avoidance of social Activities	___ Finger swelling	___ Ringing in the ears

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___ Backache	___ Food sensitivity	___ Runny nose
___ Bladder irritation & tenderness	___ Forgetfulness	___ Seizures
___ Bleeding gums	___ Headaches	___ Sensitivity to light and noise
___ Bloating	___ Herpetic outbreak	___ Sex drive change
___ Breast swelling	___ Hives or rashes	___ Sinusitis
___ Bruising	___ Hot flashes	___ Sore throat
___ Clumsiness	___ Indecision	___ Spots in front of eyes
___ Confusion	___ Inefficiency	___ Suspicious
___ Inflammation or the covering of the eye with redness (Conjunctivitis)	___ Insomnia	___ Sweating increased
___ Constipation or diarrhea	___ Irritability	___ Tearfulness
___ Cramps	___ Joint ache/pain	___ Tension
___ Craving for salty or sweet foods	___ Leg cramps	___ Tingling in the hands and feet
___ Crying spells	___ Leg swelling	___ Tremors
___ Decreased hearing	___ Longer hours of sleep	___ Trouble concentrating
___ Decreased productivity	___ Mood swings	___ Sense of objects moving or spinning (Vertigo)
___ Decreased sex drive	___ Muscle aches/pain	___ Visual changes
___ Decreased amount of urine	___ Nausea	___ Vomiting
___ Depression	___ Palpitations	___ Weight gain

Progesterone Deficiency		
___ Anxiety, nervous behavior	___ Increased abdominal fat	___ Premenstrual tension with breast tenderness and swollen breasts

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___ Bowed back	___ Insomnia with excessive nervousness tension and anxiety	___ Reddish face
___ Bloated belly	___ Irritable, aggressive behavior	___ Sharp verbal retorts
___ Breast or ovarian cysts	___ Mood swings	___ Swollen breasts
___ Breast tenderness	___ Overweight or obese	___ Swollen belly that may be painful to pressure
___ Depression	___ Brittle bones (Osteoporosis)	___ Swollen belly that may be painful to pressure
___ Enlarged breasts	___ Pain and inflammation	___ Swollen face
___ Excessive menstruation	___ Pain in breast upon pressure	___ Swollen hands
___ Fibroids of uterus	___ Premenstrual abdominal bloating	___ Swollen thighs, legs, feet, or ankles

Progesterone Excess (Of Either Synthetic or Natural Progesterone)		
___ Abdominal bloating	___ Distractible	___ Panic attacks
___ Aches and pains	___ Dizziness	___ Pins and needles feeling
___ Acne	___ Drowsiness	___ Poor coordination
___ Alcohol sensitivity	___ Dry hair	___ Poor judgment
___ Angry outbursts	___ Eye pain	___ Poor memory
___ Anxiety	___ Facial swelling	___ Poor vision
___ Appetite changes especially lack of appetite	___ Fatigue	___ Rapid heart beat
___ Asthmatic attacks	___ Fear of going out alone	___ Restlessness
___ Avoidance of social activities	___ Finger swelling	___ Ringing in the ears
___ Backache	___ Food sensitivity	___ Runny nose

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___ Bladder irritation & tenderness	___ Forgetfulness	___ Seizures
___ Bleeding gums	___ Headaches	___ Sensitivity to light and noise
___ Bloating	___ Herpetic outbreak	___ Sex drive change
___ Breast swelling	___ Hives or rashes	___ Sinusitis
___ Bruising	___ Hot flashes	___ Sore throat
___ Clumsiness	___ Indecision	___ Spots in front of eyes
___ Confusion	___ Inefficiency	___ Suspicious
___ Inflammation or the covering of the eye with redness (Conjunctivitis)	___ Insomnia	___ Sweating increased
___ Constipation or diarrhea	___ Irritability	___ Tearfulness
___ Cramps	___ Joint ache/pain	___ Tension
___ Craving for salty or sweet foods	___ Leg cramps	___ Tingling in the hands and feet
___ Crying spells	___ Leg swelling	___ Tremors
___ Decreased hearing	___ Longer hours of sleep	___ Trouble concentrating
___ Decreased productivity	___ Mood swings	___ Sense of objects moving or spinning (Vertigo)
___ Decreased sex drive	___ Muscle aches/pain	___ Visual changes
___ Decreased amount of urine	___ Nausea	___ Vomiting
___ Depression	___ Palpitations	___ Weight gain

Testosterone Deficiency		
___ Able to achieve orgasm, but with increased difficulty	___ Hesitant or indecisive	___ Muscles shrinking (shoulders)
___ Abnormal cholesterol profile	___ Hysterical reactions	___ Muscles lax
___ Anxiety	___ Hypersensitive, hyper-emotional states	___ Overweight or obese

Healthy Living and Longevity Medical Center

Function Higher — Physically, Mentally, Sexually®

___ Back pain or sciatica	___ Indecisiveness (can not make up your mind)	___ Painful intercourse
___ Clitoris getting smaller	___ Interest in physical activity/sports has been fading recently	___ Poor body image
___ Decreased sex drive	___ Joint pain	___ Sagging cheeks, or loss of facial firmness
___ Decreased or absent orgasm	___ Lack of assertiveness	___ Reduced libido (sex drive)
___ Decreased clitoris or nipple sensitivity	___ Less dreaming	___ Thighs with cellulite (fat)
___ Depressed all day	___ Loss of armpit, pubic, or body hair	___ Thin lips
___ Droopy eyelids	___ Loss of coordination and balance	___ Thinning and dry hair
___ Dry, thin skin with poor elasticity	___ Low energy	___ Urinary incontinence
___ Dry eyes	___ Low self-esteem, and sense of security	___ Vertical wrinkles above upper lip
___ Excessive fears, anxieties	___ Mild depression	___ Weight gain and decline in muscle tone (for example, sagging upper arms and cheeks)
___ Excessively emotional	___ Mild depression	___ Worries unnecessarily
___ Flat hair	___ More passive in attitudes and behavior	
___ Fatigue, decreased energy, loss of stamina	___ Muscle loss despite adequate caloric and protein (for example: chicken, meat, fish, soy) intake	

Testosterone Excess		
___ Abdominal hair above pubis up to navel	___ Cravings for salts or sugars	___ Oily skin or hair
___ Acne	___ Depression	___ Infertility

Healthy Living and Longevity Medical Center

Function Higher — Physically, Mentally, Sexually®

___ Aggressiveness, bossiness	___ Dominant character	___ Irregular periods
___ Agitation	___ Excessive libido (sex drive)	___ Loss of head hair with growth of facial hair
___ Anger	___ Excessively aggressive, authoritarian character	___ Masculine tone to voice
___ Breast tenderness	___ Fatigue	___ Mood swings
___ Body hair increased on thighs	___ Droopy breasts	___ Sparse hair around cheeks
___ Changes in memory	___ Fluid retention	___ Sparse hair around nipples
___ Clitoral swelling, increased sensitivity	___ Hair loss	___ Weight gain (apple body shape)

Thyroid Hormone Deficiency		
___ Agitation	___ Flat feet	___ Pale Face
___ Anxiety or panic attacks	___ Fluid retention	___ Poor appetite for food
___ Apathy	___ Heat intolerance, inability to sweat in a hot climate	___ Poor circulation
___ Bloating and constipation	___ Hoarse, husky voice	___ Prone to ear, nose, and throat infections
___ Brittle slow growing nails	___ Inability to concentrate	___ Prone to weight gain, but difficult weight loss when dieting
___ Carpel tunnel syndrome	___ Insomnia	___ Puffy face
___ Cold hands and/or feet	___ Lethargy, apathy	___ Reduced heart rate
___ Cold intolerance, easily shivers	___ Loss of lateral 1/3 of eyebrows	___ Sleepy during the day especially when resting
___ Constipation	___ Low body temperature	___ Slow movements

Healthy Living and Longevity Medical Center

Function Higher — Physically, Mentally, Sexually®

___ Depression	___ Low blood pressure	___ Slow speech or slow thinking or reaction
___ Decreased memory	___ Menstrual irregularities	___ Sparse, coarse, dry hair
___ Decreased sexual interest	___ Morning fatigue, fatigue when taking a rest	___ Swollen face particularly under eyelids
___ Difficulty getting out of bed in the morning	___ Morning stiffness	___ Swollen hands, feet, legs, abdomen-swollen all over
___ Diffuse hair loss	___ Muscle and joint pain	___ Swollen lips or tongue
___ Dry skin, hair, or dry scaly elbows	___ Muscle cramps	___ Thickening of skin around the elbows
___ Easily distracted, poor concentration, poor attention	___ Muscle weakness	___ Thinning of eyebrows in the outer 1/3 region
___ Excessive intake of caffeinated beverages	___ Needs to wear supplementary warm clothes in all seasons	___ Yellowish tint of skin over the palms and soles
___ Feel best in the evening when physically or mentally active	___ Overweight, obese	

Vasopressin (Antidiuretic hormone, ADH) Deficiency		
___ Bedwetting	___ Easily distracted (more frequent in stressful situations)	___ Tendency to drink a lot during the day and through the night
___ Crow's feet (wrinkles) around eyes	___ Easy bruising	___ Thirsty all the time
___ Dehydrated appearance	___ Easy wrinkling	___ Tiny skin folds in the elbow fold
___ Difficulties learning and in adapting to new situations (more frequent in stressful situations)	___ Exaggerated thirst	___ Tiny skin folds in the face

Healthy Living and Longevity Medical Center

Function Higher — Physically, Mentally, Sexually®

___ Difficulty in memorizing or learning (more frequent in stressful situations)	___ Forgetful (more frequent in stressful situations)	___ Tongue with teeth marks visible around boarders
___ Difficulty learning at school	___ Sharp skin fold above the eyes	___ Urgent need to quickly run to the bathroom after drinking
___ Disturbed sleep because of the recurrent need to go to the bathroom to urinate during the night	___ Sharp, skin grooves on the palm and fingers	___ Urinates more than 2 times at night.
___ Dry tongue	___ Sunken eyes (deep in orbits)	___ Urinates more than 5 times during the day

Comments to more fully explain your symptoms or list others not mentioned in this form:

_____

_____

Patient Signature: _____ Date: _____