

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: ____/____/____

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 TELPHONE NUMBER IF YOU HAVE THIS INFORMATION):

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 your 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
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2. 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.

a. _____

b. _____

c. _____

Other _____

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

- 3b. Past medical conditions? _____

- 3c. Have you ever had or been told you had strep throat? __Yes __ No

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

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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

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- 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? _____

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15. Do you wear seat belts consistently? Yes No

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

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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.

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
	

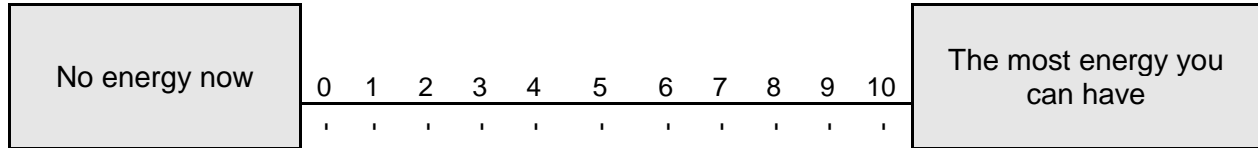
No energy at 2-3 PM	0	1	2	3	4	5	6	7	8	9	10	The most energy you can have
	

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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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

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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. Best recollection

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? _____

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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 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

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):

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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?

Health Changes Questionnaire / Testosterone Deficiency Symptoms

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 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.

Adult-Onset Growth Hormone & IGF-1 Deficiency		
<input type="checkbox"/> Abdominal obesity, fat belly	<input type="checkbox"/> Gray or white hair	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic anxiety without any reason	<input type="checkbox"/> Great difficulty in performing multiple tasks	<input type="checkbox"/> Overweight or obese due to progressively increased appetite and worsened in adult years

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___ Cold intolerance	___ Gynecomastia (man boobs or man boobs that are drooping)	___ Paler hair
___ Darker skin that became paler	___ Impaired emotional reactions	___ Penis getting smaller
___ Decreased muscle strength	___ Impaired psychological well-being and quality of life, lacking inner peace	___ Poor general health
___ Deep wrinkled forehead	___ Impaired social status (lower professional position, lower income, poor social integration, often without partner, still living with parents)	___ Poor appetite for meat
___ Deficient muscle mass	___ Inability to lose weight with diet and exercise	___ Poor memory
___ Depression	___ Intensified jet lag effect	___ Poor school performance
___ Difficulty recovering when not having slept enough	___ Joint pains under stressful conditions	___ Possible lower resistance to stress
___ Dramatizing: outbursts of panic and anxiety; may collapse from minor stress	___ Kyphosis (bowed back, stooped over)	___ Recovering very difficult
___ Drooping of eye lids (upper or lower lids)	___ Lack of inner peace	___ Receding gums and jaw bone
___ Droopy triceps (lower arm muscles sagging) or other muscles (like draperies hanging)	___ Lack of concentration	___ Reduced aerobic and anaerobic capacity (easily tire)
___ Droopy nose tip	___ Lack of self confidence, assurance, leadership (afraid of what today will bring)	___ Reduced muscle and strength
___ Dry skin	___ Lacking sexual potency	___ Resistant to new ideas and situations
___ Erectile dysfunction (lack volume and persistence of erections)	___ Lax scrotum (skin surrounding testicles dropping)	___ Sagging of body silhouette: sagging cheeks, sagging belly or sagging buttocks

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<input type="checkbox"/> Excessive emotional reactions, sharp verbal retorts	<input type="checkbox"/> Less self control	<input type="checkbox"/> Smaller shoulders, dropping triceps, wrinkled hands, small hips, sagging inner sides of thigh
<input type="checkbox"/> Excessive need for sleep	<input type="checkbox"/> Less vitality or energy	<input type="checkbox"/> Sore feet after long walks
<input type="checkbox"/> Excessive thirst and drinking	<input type="checkbox"/> Light sleep	<input type="checkbox"/> Shrinking penis
<input type="checkbox"/> Exhausted, especially after midnight	<input type="checkbox"/> Loose skin folds under the chin	<input type="checkbox"/> Stretch marks on thighs
<input type="checkbox"/> Exhausted with poor or no recovery	<input type="checkbox"/> Loss of skin tone	<input type="checkbox"/> Sunburned skin occurs easily
<input type="checkbox"/> Eye brow thinning	<input type="checkbox"/> Low or lower capacity for sexual intercourse	<input type="checkbox"/> Tendency to be depressed
<input type="checkbox"/> Face appears pale (in Caucasians)	<input type="checkbox"/> Low or lower frequency and intensity of erotic fantasies	<input type="checkbox"/> Thinning of eyebrows
<input type="checkbox"/> Flat feet, collapsed arches	<input type="checkbox"/> Lower or lower sexual arousal, decreased sex drive	<input type="checkbox"/> Thinning of lips
<input type="checkbox"/> Flat or non curling hair. Lack of hair volume.	<input type="checkbox"/> Low or lower skin sensitivity to sexual caress	<input type="checkbox"/> Thinning nose with the tip pointing downward
<input type="checkbox"/> Fatty buttocks	<input type="checkbox"/> Low self esteem	<input type="checkbox"/> Thinning of skin with hair loss
<input type="checkbox"/> Fatty thighs	<input type="checkbox"/> Muscle loosening	<input type="checkbox"/> Tiny fine skin folds (more apparent with finger pressure)
<input type="checkbox"/> Fatty cushions above the knees	<input type="checkbox"/> More body fat with skin thinning and muscle weakness, flabby belly	<input type="checkbox"/> Thick thighs with cellulite
<input type="checkbox"/> Flat appearing hair	<input type="checkbox"/> More pronounced wrinkling	<input type="checkbox"/> Tendency toward social isolation
<input type="checkbox"/> Feeling rapidly aging, feeling of profound physical degradation	<input type="checkbox"/> Muscle loosening	

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

Calcitonin Deficiency		
<input type="checkbox"/> Greater pain sensitivity	<input type="checkbox"/> History of trauma to thyroid gland with sudden onset of symptoms (from one day to the next)	<input type="checkbox"/> Tired
<input type="checkbox"/> Greater predisposition to pain	<input type="checkbox"/> Osteoporosis (brittle bones)	<input type="checkbox"/> Nausea or vomiting

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<input type="checkbox"/> bowed back, hunched appearance	<input type="checkbox"/> Stress that triggers migraine headaches	<input type="checkbox"/> Lack of appetite
<input type="checkbox"/> Crushed spine	<input type="checkbox"/> Pain in the neck, or back	<input type="checkbox"/> Feeling unwell
<input type="checkbox"/> Bulging disc(s) in spine	<input type="checkbox"/> Nervous tension	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Scar from surgery for removal of thyroid (check only for Yes).	<input type="checkbox"/> Low energy, fatigue	

Cortisol Deficiency		
<input type="checkbox"/> Acute allergies: runny nose, asthma, food allergies	<input type="checkbox"/> Heavy sweating in armpits	<input type="checkbox"/> Prone to infections: viral (flu, mono) bacterial (affecting ears, nose and throat)
<input type="checkbox"/> Brownish skin in armpit fold	<input type="checkbox"/> History of Gastroenteritis, bloating or abdominal pain	<input type="checkbox"/> Recurrent tendon pains, especially sensitive to pressure
<input type="checkbox"/> Brown skin in elbow fold	<input type="checkbox"/> Hollow cheeks	<input type="checkbox"/> Salty food cravings
<input type="checkbox"/> Brown skin folds in palms	<input type="checkbox"/> Inflammatory disease such as Lupus or Rheumatoid Arthritis	<input type="checkbox"/> Sharp verbal retorts, use of strong, dramatized words
<input type="checkbox"/> Confusion, absentmindedness, especially in stressful situations	<input type="checkbox"/> Intense hunger attacks	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Dark circles under eyes	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sugar cravings
<input type="checkbox"/> Day-dreaming, empty headedness	<input type="checkbox"/> Localized muscle pains	<input type="checkbox"/> Suntan easily
<input type="checkbox"/> Depigmented skin areas (vitilago)	<input type="checkbox"/> Low energy, fatigue, "burned out"	<input type="checkbox"/> Underweight, with difficulty gaining weight
<input type="checkbox"/> Excessive compassion for the pain of others	<input type="checkbox"/> Memory loss in stressful situations	<input type="checkbox"/> Tired look

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<input type="checkbox"/> Excessive emotions: outbursts of anger or anxiety	<input type="checkbox"/> Painful sinus points	<input type="checkbox"/> Very negative attitudes
<input type="checkbox"/> Excessive sensitivity to human suffering	<input type="checkbox"/> Paranoid-like reactions: accusatory behavior, quarrelsome	<input type="checkbox"/> Wet palms
<input type="checkbox"/> Feeling like being a 'victim'	<input type="checkbox"/> Poor resistance to stress, or great difficulty to function well in stressful situations or even to react to stressful situations	<input type="checkbox"/> Yellow-brownish skin of face
<input type="checkbox"/> Frequent screaming or yelling	<input type="checkbox"/> Recent hair loss in patches	

Cortisol Excess		
<input type="checkbox"/> Binge eating	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Shakiness between meals
<input type="checkbox"/> Confusion	<input type="checkbox"/> Irritability	<input type="checkbox"/> Thin skin
<input type="checkbox"/> Cravings for sugar	<input type="checkbox"/> Low energy	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Muscle weakness	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Night sweats	

Dehydroepiandrosterone (DHEA) Deficiency		
<input type="checkbox"/> Decrease in muscle strength and lean body mass	<input type="checkbox"/> Low sexual desire	<input type="checkbox"/> Poor muscle development
<input type="checkbox"/> Decreased erections	<input type="checkbox"/> Moderate anxiety	<input type="checkbox"/> Poor quality of life and feeling of wellness
<input type="checkbox"/> Dry eyes, or dry skin	<input type="checkbox"/> Moderate fatigue	<input type="checkbox"/> Poor sleep

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<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Overwhelming stress	<input type="checkbox"/> Pubic hair thinning or poorly developed
<input type="checkbox"/> Joint soreness	<input type="checkbox"/> Poorly developed or receding hair in armpits	<input type="checkbox"/> Reduced or loss of pubic hair
<input type="checkbox"/> Low resistance to noise or stress	<input type="checkbox"/> Poorly developed or receding hair in armpits	

Dysbiosis (Abnormal Function Due to Changes in Gut Bacteria)		
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea
<input type="checkbox"/> Anxiety and depression	<input type="checkbox"/> Fever of unknown origin	<input type="checkbox"/> Palpitations (feeling your heart beat)
<input type="checkbox"/> Arthralgias (painful joints)	<input type="checkbox"/> Flatulence (farting)	<input type="checkbox"/> Phlebitis (inflamed veins)
<input type="checkbox"/> Belching, bloating, burning (heartburn)	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Pruritis (itching)
<input type="checkbox"/> Brain fog	<input type="checkbox"/> Halitosis (bad breath)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cramps and spasms	<input type="checkbox"/> Malaise (feeling no energy)	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Cognitive and memory deficit	<input type="checkbox"/> Myalgias (muscle pains)	

Insulin Deficiency		
<input type="checkbox"/> Apathy	<input type="checkbox"/> Fatigue, general weakness	<input type="checkbox"/> Low to normal glucose (if known)
<input type="checkbox"/> Arms are underdeveloped or droopy arm muscles	<input type="checkbox"/> Feet are thin and poorly muscle mass	<input type="checkbox"/> Low to normal glycosylated hemoglobin (HbA1C) (if known)
<input type="checkbox"/> Belly too thin, flat	<input type="checkbox"/> Hips and buttocks are narrow, thin hips and/or buttocks, lacking fat	<input type="checkbox"/> Moments of low alertness, inattention

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<input type="checkbox"/> Breasts are sagging	<input type="checkbox"/> Legs are thin, poor muscle mass	<input type="checkbox"/> Neck is thin and poorly muscled
<input type="checkbox"/> Breasts have poor fat accumulation	<input type="checkbox"/> Loss of fat mass	<input type="checkbox"/> Sweets and sugars are not tolerated well
<input type="checkbox"/> Chest poorly developed muscles	<input type="checkbox"/> Low insulin (if known)	<input type="checkbox"/> Thin, hollow face
<input type="checkbox"/> Difficulty in receiving and giving love	<input type="checkbox"/> Low libido	<input type="checkbox"/> Underweight body and or extremely thin

Mental Symptoms of Testosterone Deficiency		
<input type="checkbox"/> Anxiety or increased nervousness or panic attacks'	<input type="checkbox"/> Feeling depressed or negative	<input type="checkbox"/> Have you lost your 'edge' or feel that you are 'past your peak'
<input type="checkbox"/> Becoming a, "couch potato"?	<input type="checkbox"/> Feeling irritable or angry more often	<input type="checkbox"/> Loss of motivation or initiative to start new projects or old hobbies
<input type="checkbox"/> Decreased assertiveness and decreased desires	<input type="checkbox"/> Feeling stressed or 'burned out'	<input type="checkbox"/> Pervasive sense of fatigue, wake up tired
<input type="checkbox"/> Decreased mental sharpness	<input type="checkbox"/> Feeling that work, relationships, past pleasures have lost significance	<input type="checkbox"/> Unable to concentrate or maintain focus
<input type="checkbox"/> Do you have sleep problems (difficulty falling to sleep, waking up early and feeling tired, poor sleep, (sleeplessness)	<input type="checkbox"/> Forgetful, poor memory	

Metabolic Disease or Changes related to Testosterone Deficiency		
<input type="checkbox"/> Adrenal gland problems	<input type="checkbox"/> Increase in cholesterol, triglycerides, or decreased HDL	<input type="checkbox"/> Shortness of breath with exercise, exertion or climbing stairs

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<input type="checkbox"/> Development of chest pains, heart problems, or blocked arteries	<input type="checkbox"/> Past heart attack, bypass surgery or stent placement	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Past stroke or TIA (mini-stroke)	
<input type="checkbox"/> Higher blood sugar or the onset of adult Type II Diabetes	<input type="checkbox"/> Racing heart, extra beats, atrial fibrillation	

Oxytocin Deficiency		
<input type="checkbox"/> (If) Married, marriage less happy	<input type="checkbox"/> Drier glands penis with sex	<input type="checkbox"/> No smile or smiles less
<input type="checkbox"/> Circle of friends is decreasing	<input type="checkbox"/> Easy pain perception	<input type="checkbox"/> Not warm-hearted
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Excess pain sensitivity	<input type="checkbox"/> Orgasm becoming or is less easy to achieve
<input type="checkbox"/> Less social involvement	<input type="checkbox"/> Excessively (emotionally) detached from others	<input type="checkbox"/> Pale face
<input type="checkbox"/> Mainly retains old friends, but very few, if any new friends	<input type="checkbox"/> Joyless appearance, unhappy face	<input type="checkbox"/> Sex feels less fantastic than before
<input type="checkbox"/> Poor lifeless gaze	<input type="checkbox"/> Limited emotional expression	<input type="checkbox"/> Sex feels mechanical and not as an intense romantic love experience
<input type="checkbox"/> Teamwork possible but less easy than before	<input type="checkbox"/> Low or lower ejaculation volume	<input type="checkbox"/> Warm-hearted before, but now more introverted or colder
<input type="checkbox"/> Decreased ability to ejaculate or loss of ejaculation	<input type="checkbox"/> Lower sex drive and arousal	
<input type="checkbox"/> Developed sex drive but declining	<input type="checkbox"/> No emotional flush	

In addition to the above directions, please indicate, if applicable, whether or not the problem is a long term problem (How many months?).

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Physical Changes related to Testosterone Deficiency		
<input type="checkbox"/> Arthritis in the shoulders, hands, hips, knees, or feet	<input type="checkbox"/> Frequent neck or back pains	<input type="checkbox"/> Increasing central weight- "beer belly"
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Chronic inflammatory disease, colitis, rheumatoid arthritis	<input type="checkbox"/> Harder to recover from heavy exercise or workout	<input type="checkbox"/> Increased tendency for strains-muscle pulls
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Decreased athletic performance, agility, Quickness	<input type="checkbox"/> Have you gained fat and/or lost muscle Mass	<input type="checkbox"/> Lack of competitive drive in sports
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Decrease in muscle size, fullness, tone, increased "flabbiness"	<input type="checkbox"/> Headaches or recent onset of migraine type Headaches	<input type="checkbox"/> Leg cramps or swollen ankles
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Decreased strength or stamina	<input type="checkbox"/> Harder to recover from heavy exercise or workout	<input type="checkbox"/> Lightness, dizziness, ringing in the ears
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Diminished effects from workouts-strength, tone, muscle mass	<input type="checkbox"/> Have you gained fat and/or lost muscle Mass	<input type="checkbox"/> Loss of body hair and decreased beard growth rate
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Do you have a decrease in beard growth	<input type="checkbox"/> Headaches or recent onset of migraine type Headaches	<input type="checkbox"/> Sleep problems, sleep apnea, night sweats or hot flashes
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Do you recover poorly from physical exertion and/or exercise	<input type="checkbox"/> Increase in breast fat	<input type="checkbox"/> Shortness of breath at low levels of exertion
Long-term Y/N	Long-term Y/N	Long-term Y/N
<input type="checkbox"/> Emphysema or asthma	<input type="checkbox"/> Increasing central weight- "beer belly"	<input type="checkbox"/> Varicose veins, hemorrhoids, varicocele
Long-term Y/N	Long-term Y/N	Long-term Y/N

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<input type="checkbox"/> Feeling sore all over, aches in muscles or joints	<input type="checkbox"/> Increased tendency for strains-muscle pulls	<input type="checkbox"/> Weight gain or loss
Long-term Y/N	Long-term Y/N	Long-term Y/N

Pregnenolone Deficiency		
<input type="checkbox"/> Abdomen is painful if pressed	<input type="checkbox"/> Heart rate is quick (more than 80 beats/min)	<input type="checkbox"/> Sharp wrinkles
<input type="checkbox"/> Decreased libido (sexual energy)	<input type="checkbox"/> Lack of mental firmness and aggressiveness	<input type="checkbox"/> Small or regressing penis
<input type="checkbox"/> Deficient muscle mass and or bone mass	<input type="checkbox"/> Memory worse when under stressful situation	<input type="checkbox"/> Smaller or lax testicles
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Moderate fatigue (chronic)	<input type="checkbox"/> Soft eye balls (eyes feel soft to pressure)
<input type="checkbox"/> Erectile dysfunction and/or decrease in ejaculate volume	<input type="checkbox"/> Nervous behavior	<input type="checkbox"/> Sugar cravings
<input type="checkbox"/> Excessive thirst and drinking	<input type="checkbox"/> Pigmented spots on face	<input type="checkbox"/> Sunken eyes
<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Poor muscle strength	<input type="checkbox"/> Sweating hands and armpits during stress
<input type="checkbox"/> Feeling faint when standing up	<input type="checkbox"/> Poor short term memory	<input type="checkbox"/> Thin, hollow face
<input type="checkbox"/> Foggy, absent-minded look	<input type="checkbox"/> Reduced color vision	<input type="checkbox"/> Thin muscles
<input type="checkbox"/> Forgetful behavior	<input type="checkbox"/> Salt or sugar cravings	<input type="checkbox"/> Unclear thinking

Progesterone Deficiency		
<input type="checkbox"/> Abdominal obesity	<input type="checkbox"/> Enlarged or hardened prostate (if known)	<input type="checkbox"/> Overweight or obese

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Function Higher — Physically, Mentally, Sexually ®

___ Anxious, nervous behavior	___ Face is red or swollen	___ Prostate infections
___ Back with a lot of body hair (hirsutism)	___ Irritable, aggressive behavior	___ Superficial, nervous sleep
___ Bloating belly	___ Lack of inner peace, especially in the evening	___ Swollen hands
___ Bowed back (kyphosis)	___ Male pattern baldness	___ Tenses shoulder muscles or upper back, especially in the evening
___ Difficulty urinating	___ Man Boobs (Gynecomastia)	___ Urine stream reduced and needing more time to urinate

Sexual Function related to Testosterone Deficiency		
___ Decreased ability to maintain full erection after penetration	___ Difficulty achieving an erection	___ Loss of sensation of the penis
___ Decreased early morning erections	___ Diminished libido	___ Premature ejaculation - recent _____, long term _____
___ Decreased fullness or turgidity	___ Diminished strength of orgasm	___ Response to Viagra, Levitra,, Cialis, _____
___ Decreased volume of ejaculate?	___ Length in time in years since first noticed	___ Use of other methods for achieving erections (pump, injections)

Testosterone Deficiency		
___ Abnormal cholesterol profile	___ Indecisiveness (can not make up your mind)	___ Poor body image
___ Anxiety	___ Less dreaming	___ Sagging cheeks

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Function Higher — Physically, Mentally, Sexually ®

<input type="checkbox"/> Decreased sex drive	<input type="checkbox"/> Loss of armpit, pubic, or body hair	<input type="checkbox"/> Thin lips
<input type="checkbox"/> Droopy eyelids	<input type="checkbox"/> Loss of coordination and balance	<input type="checkbox"/> Thinning and dry hair
<input type="checkbox"/> Dry, thin skin with poor elasticity	<input type="checkbox"/> Loss of self-esteem and sense of security	<input type="checkbox"/> Weight gain and decline in muscle tone (for example, sagging upper arms and cheeks)
<input type="checkbox"/> Fatigue, decreased energy, loss of stamina	<input type="checkbox"/> Mild depression	
<input type="checkbox"/> Hypersensitive, hyper-emotional states	<input type="checkbox"/> Muscle loss despite adequate caloric and protein (for example: chicken, meat, fish, soy) intake	

Testosterone Excess		
<input type="checkbox"/> Acne or oily skin	<input type="checkbox"/> Cravings for salts or sugars	<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Aggressiveness, bossiness	<input type="checkbox"/> Depression	<input type="checkbox"/> Loss of head hair with growth of facial hair
<input type="checkbox"/> Agitation	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Anger	<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Weight gain (apple body shape)
<input type="checkbox"/> Changes in memory	<input type="checkbox"/> Infertility	

Thyroid Hormone Deficiency		
<input type="checkbox"/> Agitation	<input type="checkbox"/> Flat feet	<input type="checkbox"/> Pale Face
<input type="checkbox"/> Anxiety or panic attacks	<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Poor appetite for food
<input type="checkbox"/> Apathy	<input type="checkbox"/> Heat intolerance, inability to sweat in a hot climate	<input type="checkbox"/> Poor circulation

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Function Higher — Physically, Mentally, Sexually ®

<input type="checkbox"/> Bloating and constipation	<input type="checkbox"/> Hoarse, husky voice	<input type="checkbox"/> Prone to ear, nose, and throat infections
<input type="checkbox"/> Brittle slow growing nails	<input type="checkbox"/> Inability to concentrate	<input type="checkbox"/> Prone to weight gain, but difficult weight loss when dieting
<input type="checkbox"/> Carpel tunnel syndrome	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Puffy face
<input type="checkbox"/> Cold hands and/or feet	<input type="checkbox"/> Lethargy, apathy	<input type="checkbox"/> Reduced heart rate
<input type="checkbox"/> Cold intolerance, easily shivers	<input type="checkbox"/> Loss of lateral 1/3 of eyebrows	<input type="checkbox"/> Sleepy during the day especially when resting
<input type="checkbox"/> Constipation	<input type="checkbox"/> Low body temperature	<input type="checkbox"/> Slow movements
<input type="checkbox"/> Depression	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Slow speech or slow thinking or reaction
<input type="checkbox"/> Decreased memory	<input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Sparse, coarse, dry hair
<input type="checkbox"/> Decreased sexual interest	<input type="checkbox"/> Morning fatigue, fatigue when taking a rest	<input type="checkbox"/> Swollen face particularly under eyelids
<input type="checkbox"/> Difficulty getting out of bed in the morning	<input type="checkbox"/> Morning stiffness	<input type="checkbox"/> Swollen hands, feet, legs, abdomen-swollen all over
<input type="checkbox"/> Diffuse hair loss	<input type="checkbox"/> Muscle and joint pain	<input type="checkbox"/> Swollen lips or tongue
<input type="checkbox"/> Dry skin, hair, or dry scaly elbows	<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Thickening of skin around the elbows
<input type="checkbox"/> Easily distracted, poor concentration, poor attention	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Thinning of eyebrows in the outer 1/3 region
<input type="checkbox"/> Excessive intake of caffeinated beverages	<input type="checkbox"/> Needs to wear supplementary warm clothes in all seasons	<input type="checkbox"/> Yellowish tint of skin over the palms and soles
<input type="checkbox"/> Feel best in the evening when physically or mentally active	<input type="checkbox"/> Overweight, obese	

Urologic Symptoms related to Testosterone Deficiency		
<input type="checkbox"/> Enlarged prostate (BPH)	<input type="checkbox"/> Night time urination _____ X per night	<input type="checkbox"/> Prostatitis: recurrent _____ chronic _____

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___ Increased or normal range PSA (range _____ ng/dl)	___ Non-medical treatments- Saw Palmetto or combination (other) _____	___ Treatment(s): Surgery ___ Radiation ___ Cryo ___ Lupron ___ or drugs
___ Infertility problem	___ Prostate cancer (year diagnosed _____ Gleason Score _____)	___ Urinary frequency, reduced flow, dribbling, or leakage
___ Medical treatments: Proscar ___ Propecia ___ Avodart ___ Flomax ___	___ Prostate treatment for BPH (TURP ___ TUNA ___ Laser ___) year _____	___ Vasectomy (Year _____) Varicocele ___ Hydrocele ___ Hernia ___

Vasopressin (Antidiuretic hormone, ADH) Deficiency		
___ Bedwetting	___ Dry tongue	___ Sharp, skin grooves on the palm and fingers
___ Crow's feet (wrinkles) around eyes	___ Easily distracted (more frequent in stressful situations)	___ Sunken eyes (deep in orbits)
___ Dehydrated appearance	___ Easy bruising	___ Tongue with teeth marks visible around borders
___ Difficulties learning and in adapting to new situations (more frequent in stressful situations)	___ Easy wrinkling	___ Urgent need to quickly run to the bathroom after drinking
___ Difficulty in memorizing or learning (more frequent in stressful situations)	___ Exaggerated thirst	___ Urinates more than 2 times at night.
___ Difficulty learning at school	___ Forgetful (more frequent in stressful situations)	___ Urinates more than 5 times during the day
___ Disturbed sleep because of the recurrent need to go to the bathroom to urinate during the night	___ Sharp skin fold above the eyes	

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

Patient Signature: _____ Date: _____