STAY FIT FOREVER

Health & Nutrition Intake Evaluation

Date of Medical Evaluation: _____ /_____ / _____

Name of Patient: _____ _____ ___
First *Last* *MI*

Age on Day of the Exam: ____ DOB_____

Profession: _____

Phone Number: _____ (888.888.8888) Email Address: _____

Primary Care Physician: _____

Telephone Number: ( ) -

Aging X Factor Assessment:

As we age, many of us experience a progressive deterioration in one or more aspects of our personal health and fitness. If you could improve anything, what would be the top two or three areas that you would most like to improve upon?

1.

2.

3.

Social & Career Challenges:

1. Are you married? ☐ Yes ☐ No If yes, how many years? _____
2. Do you have any children? ☐ Yes ☐ No If yes, ages/how many? _____
3. How many hours a day do you work? _____ 4. How many days a week do you work? _____
5. Do you smoke? ☐ Yes ☐ No
6. How would you characterize your alcoholic consumption?

☐ Never ☐ Occasional ☐ Moderate ☐ Socially Drinks per week _____

7. Describe any other professional, social or family challenges to reaching your personal health and wellness goals:

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Current Diet & Nutritional Philosophy:

1. How would you characterize your general overall diet?

2. What is your ideal body weight? _____ 3. What is your ideal body fat composition? _____

4. What are your biggest challenges to maintaining your ideal body weight?

Current Exercise Regimen:

1. Aerobic Activities (Type):_____

Hours per week ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

2. Resistance Exercise: Hours Per week

☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

3. Describe Your Favorite Recreational Activities:

4. Ideal Fitness Goals:

Androgen Deficiency in Aging Male (ADAM) Survey:

Which of the following symptoms apply to you at this time?

Mark an X in the most appropriate box.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

1.	Do you have a decrease in libido?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2.	Do you have a lack of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3.	Do you have a decrease in strength and /or endurance?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4.	Have you lost height?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5.	Have you noticed a decreased enjoyment in life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6.	Are you sad and / or grumpy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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Androgen Deficiency in Aging Male (ADAM) Survey: (cont.)

7. Are you erections less strong?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Have you noticed a recent deterioration in your ability to play sports?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Are you falling asleep after dinner?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Has there been a recent deterioration in your work performance?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Have you noticed any diminished memory or cognitive function?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. How many hours do you sleep at night? _____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Have you ever been diagnosed with sleep apnea?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Epworth Sleeping Scale (*ESS:*)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

	1 Mild	2 Moderate	3 High
1. Sitting and reading	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place	☐ 1	☐ 2	☐ 3
4. As a passenger in a car without a break	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch without alcohol	☐ 1	☐ 2	☐ 3
8. In a car, while stopped in traffic.	☐ 1	☐ 2	☐ 3

Cognitive – Brain Symptom Score:

1. I lose things often? (keys, pens, PDAs)	☐ Yes	☐ No
2. It is harder to find my car in a big parking area?	☐ Yes	☐ No
3. It is difficult to remember a 7 digit phone number to dial it?	☐ Yes	☐ No
4. I find myself writing lists to help my memory more than I used to?	☐ Yes	☐ No
5. I am forgetting names of movie and sport stars I knew well?	☐ Yes	☐ No
6. It is easier to remember an event from 20 years ago than 2 days ago?	☐ Yes	☐ No
7. I have trouble dealing with math problems (balancing my check book, calculating% for tipping)	☐ Yes	☐ No
8. I am challenged when I have to learn new things (software programs, instructions to put together A new barbecue grill)	☐ Yes	☐ No
9. During a detailed lecture or meeting, my mind starts drifting sooner than it used to.	☐ Yes	☐ No
10. When working on a project, I find it hard to get back into the groove after being interrupted by a Phone call or office visitor	☐ Yes	☐ No

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Cage Alcohol Survey

Have you ever felt like you should cut down on your drinking?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
Have you ever felt bad or guilty about drinking?	☐ Yes	☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No

Musculo-Skeletal Injuries:

1.
2.
3.
4.

Past Medical History:

1.
2.
3.
4.

Past Surgical History:

1.
2.
3.
4.

Family History:

1. Father's Health:

   If deceased, age _____ at death and cause._____

2. Mother's Health

   If deceased, age _____ at death and cause._____

3. Siblings

   If deceased, age _____ at death and cause._____

Medication & Food Allergies:

Medication Name or Food Type	Adverse Reaction

Preventative Surveillance Clinical Studies (Abnormalities):

1. Date of Last Comprehensive Eye Examination:
2. Date of Last Dermatology Examination:
3. Date of Last Dental Examination and Cleaning:
4. Date of Last Digital Rectal Examination & PSA:
5. Date of Last Upper Endoscopy:
6. Date of Last Colonoscopy:
7. Bone Density Scan:
8. Cardiac Angio or Calcium CT scan:

Current Medications:

	Medication	Strength	Taken how often	Reason for taking medication
1.				
2.				
3.				
4.				
5.				

Current Supplements:

	Supplement	Strength	Taken How often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			