

BIOMARKER QUESTIONNAIRE

Patient Name: _____

Age _____ Sex _____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Decrease muscle mass | <input type="checkbox"/> Chronic Pain or inflammation |
| <input type="checkbox"/> Reduced Strength | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Decrease joint mobility | <input type="checkbox"/> Waking up tired |
| <input type="checkbox"/> Increase stiffness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Reduced capacity for work and exercise | <input type="checkbox"/> Longer recovery time needed for exertion |
| <input type="checkbox"/> Decrease endurance | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Significant weight loss | <input type="checkbox"/> Increase difficulty concentrating |
| <input type="checkbox"/> Increase body fat | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Increased waist to hip ratio (more fat on the abdomen and waist) | <input type="checkbox"/> Unexplained depression |
| <input type="checkbox"/> Reduced sexual drive and/or performance | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Muscle mass loss or flabbiness | <input type="checkbox"/> Increased anger or irritability |
| <input type="checkbox"/> Changes in body temperature | <input type="checkbox"/> Sensitivity to certain foods |
| <input type="checkbox"/> Sensitivity to cold or heat | <input type="checkbox"/> Craving for sugar Alcohol intolerance |
| <input type="checkbox"/> Hot flashes | |
| <input type="checkbox"/> Dryer or thinning skin and hair | |
| <input type="checkbox"/> Brown or red spots | |
| <input type="checkbox"/> Spider veins on the skin | |

Have you had any of the following tests?

- | | |
|---|--|
| <input type="checkbox"/> Complete blood count | <input type="checkbox"/> Homocysteine |
| <input type="checkbox"/> Chemistry panel | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> PSA and prostate exam for men over 40 | <input type="checkbox"/> Bone Density |
| <input type="checkbox"/> Breast exam and mammography for women | <input type="checkbox"/> Treadmill Test |
| <input type="checkbox"/> PAP Smear (for women) | <input type="checkbox"/> Estrogen Levels |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Basal Temperature | <input type="checkbox"/> Free Testosterone |
| <input type="checkbox"/> 3-5 hour glucose tolerance test | <input type="checkbox"/> IgF-1 (a marker for human growth hormone) |
| <input type="checkbox"/> Fasting insulin | <input type="checkbox"/> DHEA-S |
| <input type="checkbox"/> Blood lipids: total cholesterol, triglycerides, HDL, and LDL | <input type="checkbox"/> Cortisol |
| <input type="checkbox"/> Thyroid Studies (TSH, T4) | <input type="checkbox"/> SHBG (sex hormone binding globulin) |
| <input type="checkbox"/> Free T3 | |
| <input type="checkbox"/> Slow wound healing | |
| <input type="checkbox"/> Frquent colds or flu | |
| <input type="checkbox"/> Presence of viral infections: Shingles, HIV, Epstein Barr, HHV-6 Hepatitis | |

FAMILY HISTROY: Has anyone in your immediate family had any of the following conditions?

- Heart or coronary arterial disease (congestive heart failure, angina etc.) _____
- Atherosclerosis (hardening of the arteries) _____
- High Cholesterol or other form of abnormal lipids _____
- Heart attack or stroke _____
- Diabetes or any form of metabolic disease or obesity _____
- Cancer and list type(s) _____
- Osteoporosis or any form of bone disease _____
- Thyroid disease _____
- List any other diseases in your family _____

FATIGUE QUESTIONNAIRE

Check each applicable box if you have ever experience any of the following:

- | | |
|---|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Exhausted feelings that are not related to stress or amount of work or exercise.<input type="checkbox"/> Morning tiredness, even after a full night's sleep.<input type="checkbox"/> Depression that doesn't respond to antidepressants, diet of exercise.<input type="checkbox"/> Unexplained anxiety and panic attacks.<input type="checkbox"/> Been told that I move as if in slow motion, and take too long to respond to questions.<input type="checkbox"/> A frequently low or hoarse voice (for women).<input type="checkbox"/> Mental sluggishness and have difficulty focusing.<input type="checkbox"/> Low sex drive and don't experience significant sexual arousal.<input type="checkbox"/> High cholesterol that has been unresponsive to diet or medication.<input type="checkbox"/> A tendency to feel cold even in warm weather.<input type="checkbox"/> Chronic aches and pains not due to accidents or exercise.<input type="checkbox"/> Carpal Tunnel Syndrome.<input type="checkbox"/> Problems with allergies.<input type="checkbox"/> Difficulty losing weight. | <ul style="list-style-type: none"><input type="checkbox"/> Very dry skin.<input type="checkbox"/> I have acne or eczema.<input type="checkbox"/> Diabetes<input type="checkbox"/> Rheumatoid arthritis or other autoimmune condition.<input type="checkbox"/> Problem with my periods, including abnormal menstrual bleeding.<input type="checkbox"/> Anemia<input type="checkbox"/> Infertility or a history of frequent miscarriages.<input type="checkbox"/> Significant menopausal symptoms.<input type="checkbox"/> A tendency to have chronic constipation even with high fiber diet.<input type="checkbox"/> Lots of hair falling out or brittle hair.<input type="checkbox"/> Vitiligo or other unusual changes in skin color.<input type="checkbox"/> Trembling of my hands or stumbling for no reason.<input type="checkbox"/> Have a family history of thyroid disorder.<input type="checkbox"/> Have previously been diagnosed with thyroid disorder. |
|---|--|

Patient Signature: _____

Date: _____

Affinity Med Spa – 8648 E SR 70, Suite B – Bradenton, FL 34202 – (941)-739-7900