Advanced Age Management
Health & Lifestyle Questionnaire

Name: _____ Date: _____ Date of Birth: / /

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Sex: ☐ M ☐ F Weight: _____ Height: _____ Age: _____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Committed Relationship

Male Andropause Screening (rate 0 to 5: 0=no symptoms, 3=mild, 5=severe):

Compare yourself to a time you felt best in adulthood	0	1	2	3	4	5
Do you have less energy than you used to?						
Have you noticed increased bodyfat, particularly in the waist?						
Have you experienced strength or muscle loss?						
Do you have less sex drive than you used to?						
Are your erections less firm or sustained?						
Do you have more muscle or joint pains?						
Are you more irritable?						
Are you happy or excited less often?						
Do you have less drive and motivation than before?						
Do you notice slower recovery from intense exercise or injury?						
Have you noticed any memory decline: slower thinking, forgetfulness, problems recalling name, dates, events?						
Has there been a deterioration in physical, mental or work performance?						
Are you experiencing trouble falling or staying asleep?						
Do you get sick more often?						

Do you feel fatigued in the evening or after exercise?						
Do you feel that you have passed your peak?						

Female Menopause Screening (rate 0 to 5: 0=no symptoms, 3=mild, 5=severe):

	0	1	2	3	4	5
Do you have less energy than you used to?						
Are you experiencing hot flashes and/or night sweats?						
Do you notice irritability or mood swings?						
Have you noticed more anxiety?						
Do you have depressed moods more often?						
Have you noticed a loss of sex drive?						
Are you experiencing vaginal dryness?						
Is your skin less firm & supple, do you notice wrinkling?						
Are you having any difficulties with concentration or focus?						
Any difficulties with memory/forgetfulness, recall of names, dates, events?						
Do you feel puffy (swelling) or have breast tenderness?						
Are you experiencing more muscle & joint aches?						
Is it difficult to fall or stay asleep?						
Any you experiencing more headaches?						
Have you had more urinary problems (frequency, more infections, urinary leaking)?						
Do you notice less exercise tolerance or more difficulty with moderate to intense physical activity?						

Are you still having regular menstrual cycles? ☐ Yes ☐ No ☐ Irregular

If no, at what age did your periods stop?

Do you have a history of:

- ☐ Breast Cancer
- ☐ Fibrocystic Breast
- ☐ Uterine Fibroids
- ☐ Migraine Headaches
- ☐ Ovarian Cysts
- ☐ Abnormal Uterine Bleeding
- ☐ Blood Clots/PE/DVT
- ☐ First Degree Relative w/ Breast Cancer
- ☐ Frequent Urinary Tract Infections
- ☐ Recurrent Vaginal Infections
- ☐ Early Surgical Menopause (removed ovaries)
- ☐ History of Abnormal Pap tests

Please check if you have any of the following medical issues:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Blood Clot (PE or DVT)
- ☐ Recurrent Chest Pain
- ☐ Recurrent Shortness of Breath
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ History of Smoking
- ☐ Moderate - Heavy Alcohol Use
- ☐ Anemia
- ☐ Easy Bruising Bleed
- ☐ Abdominal Pain Nausea/Vomiting
- ☐ Heartburn
- ☐ Sleep Apnea
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Cancer
- ☐ Diabetes
- ☐ Adrenal Disease
- ☐ Thyroid disease
- ☐ Autoimmune disease
- ☐ Migraines
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Fibrocystic Breasts
- ☐ Ovarian Cysts
- ☐ Hx Depression
- ☐ Hx Anxiety/Panic Attack
- ☐ Seizures/Neurologic disorder
- ☐ Hx of Psychosis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Carpal Tunnel
- ☐ Joint swelling
- ☐ Cataracts
- ☐ Retinal Disease
- ☐ Glaucoma
- ☐ Multiple Concussions
- ☐ Traumatic Brain Injury
- ☐ Pituitary cancer/surgery
- ☐ Testicular or Ovarian Rupture or surgery
- ☐ Abnormal Vaginal
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Skin disorders

Please provide additional Medical History Information or Further Explanation:

_____

_____

_____

_____

_____

Do you smoke? ☐ Yes ☐ No How many years?_____ How many packs/day?_____

Do you drink alcohol? ☐ Yes ☐ No What type?_____ How many drinks/week?_____

Have you recently used anabolic steroids? ☐ Yes ☐ No

Have you ever used anabolic steroids? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Have you taken weight loss supplements? ☐ Yes ☐ No

Do you play any sports? ☐ Yes ☐ No Which sports:_____

List your favorite hobbies: _____

How well do you handle stress: ☐ Perfectly ☐ Fairly Well ☐ Some trouble ☐ Poorly

List any major stressors:_____

What are your main Wellness/Age Management goals:

1._____

2._____

3._____

Please provide the year/result of your last:

Colonoscopy:_____ Abnormal: ☐ Yes ☐ No

Mammogram:_____ Abnormal: ☐ Yes ☐ No

Bone Density:_____ Abnormal: ☐ Yes ☐ No

Chest X-ray:_____ Abnormal: ☐ Yes ☐ No

EKG:_____ Abnormal: ☐ Yes ☐ No

Cholesterol:_____ Abnormal: ☐ Yes ☐ No

Blood Sugar:_____ Abnormal: ☐ Yes ☐ No

Vision Test:_____ Abnormal: ☐ Yes ☐ No

Stress Test/Echo:_____ Abnormal: ☐ Yes ☐

Physical Exam:_____ Tetanus Update:_____

Blood screening:_____ Prostate or Pelvic Exam:_____

Do you have any of the following currently:		
☐ Chest Pain	☐ Sleep disturbance	☐ Numbness/Tingling
☐ Palpitations	☐ Hearing Loss	☐ Significant Back Pain
☐ Short of Breath	☐ Visual symptoms	☐ Large Weight Change
☐ Abdominal Pain	☐ Headache	☐ Hair Loss
☐ Blood in Stool or Urine	☐ Allergy symptoms	☐ Brittle Nails
☐ Trouble Urinating	☐ Cold symptoms	☐ Fatigue
☐ Frequent Night Urination	☐ Flu-like symptoms	☐ Depression/Anxiety
☐ Nausea/Vomiting	☐ Fevers or Chills	☐ Loss of Strength
☐ Diarrhea/Constipation	☐ Vaginal bleeding	☐ Current Cancer
☐ Digestion Problems	☐ Nipple Discharge	☐ Current Infections
☐ Muscle/Joint Pains	☐ Pain with intercourse	☐ Memory Loss
☐ Joint Swelling	☐ Unusual Skin Rash	☐ Heartburn/Stomach Ulcer

Personal Health Habits:

Do you consider your health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Not good ☐ Horrible

Exercise summary:

How many days/week do you engage in resistance training?:
How many days/week do you engage in cardiovascular exercise?:
How long is a typical exercise session?:
Do you belong to a fitness center?:
Do you have a personal trainer?:
Have you ever worked with an exercise specialist?:
Are you bored with your workouts?:
Are you achieving exercise goals?:
Are you happy with your strength & lean muscle mass?
Are you happy with your level of body fat?

Current Diet/Nutrition summary:

Do you want to lose or gain weight?:
Do you follow a healthy diet?
Do you often eat late at night?
Do you eat for comfort or to battle stress?
Do you eat 4-5 servings of vegetables/day?
Do you eat 3-5 servings of fruits/day?
How often do you eat red meat?
How often do you go out to eat?
Do you eat fish & chicken as your primary proteins?
How many times/week do you eat fast food?
Do you eat fried food?
How many days/week do you eat dessert/bakeries/candy?
Is your diet high in fiber?
Do you lose energy & crave sugar between meals?
Do you drink pop or beverages with sugar?
Have you ever worked with a nutritionist or dietitian?

Mood Assessment

	Never	Rarely	Sometimes	Always
Are you happy?				
Do you enjoy time with family & friends often?				
Feel in control of personal life and career?				
Set goals and look for new challenges?				
Participate in hobbies and creative outlets?				
Excited by the same things that used to interest you?				
Express feelings fairly well?				
Laugh often?				
Generally Expect Good things to happen?				
Become irritable or angry easily?				
Very critical of self?				
Very critical of others?				
Feel lonely?				
Feel helpless?				
Have many regrets? Guilt?				
Do you enjoy your job?				
Do you enjoy your spouse/companion?				
Are you able to concentrate when you need to?				
Do you wake up often at night or sleep excessively?				
Do you feel tired all the time?				
Any recurrent thoughts or hurting yourself or others?				

Medications and Supplements:

Please list any medications and/or supplements you take regularly:

Medication/Supplement	*Dosage (quantity and frequency)*

Thank you for taking the time to complete the Lifestyle & Wellness questionnaire!

Wishing you health & wellness,

ADVANCED SPINE JOINT
AND WELLNESS CENTER

*Advanced Age Management respects your private information and will not share this with any 3rd party