# HONG DAVIS, MD/TEXAS ANTIAGING CENTER

Patient name: DOB: ___/___/_____ Sex: Male__ Female__ Date: ___/___/20__

Tell us how you feel now, compared with your best (highest) which is 10 and your worst (lowest) is 1:

1. Energy level:
   a. When waking up: _____/10
   b. When you are up and moving around: ____/10
   c. After lunch: _____/10 After dinner: ____/10
2. Mental focus: ____/10
3. Sleep:
   a. Bedtime hour: ___pm / am: wake-up hour: ___am/pm:
   b. Number of times you get up at night? _____
   c. Do you wake up easy: Y/N Do you feel tired in the morning: Y/N?
   d. How often do you dream? A lot __ / some__ /none__
4. Mood swings: A lot __ / some__ /none__ Irritated: A lot __ / some__ /none__
5. Anxiety: A lot __ / some__ /none__ Agitation: A lot __ / some__ /none__
6. Feeling depressed: A lot __ / some__ /none__
7. Memory: worse__ / no change___ / better__
8. Concentration: worse__ / no change__ / better__
9. Motivation/Drive: worse__ / no change__ / better__
10. Sexual desire changes: decreased__ /no change__ / increased__
11. Acid reflux Y/N Abdominal fullness Y/N Bloating Y/N Indigestion Y/N
12. Bowel movement: once daily/__to __times daily/once every__ day
13. Urination: Is it more frequent than normal: Y/N Is it weak stream: Y/N
    Incomplete: Y/N Night urine, how many times: __
14. Hair thinning: Y/N Cold hands/Feet: Y/N
15. Skin tone/texture: decreased__ /no change__ /improved__
16. Hot flashes Y/N how often: ___time per day/week
17. Weight:
    a. What is your ideal weight _____ lb
    b. Are you currently on a diet? Y/N Which previous diets have you tried?
    c. Have you been doing any exercise, please specify what kind, how often?

| Questions | Yes | No |
|---|---|---|
| I am more tired/I sleep more than usual? | Yes | No |
| I have trouble falling and/or staying asleep? | Yes | No |
| I have a loss of appetite? | Yes | No |
| Am I no longer interested in intimacy? | Yes | No |
| I cry easily, and more often? | Yes | No |
| I have general aches & pains? | Yes | No |
| I feel more anxious than usual? | Yes | No |
| I fidget/restless before/during sleep? | Yes | No |
| Do things seem to irritate me more than usual? | Yes | No |
| Have I not felt like myself lately? | Yes | No |

Optimal health goals you want to reach:

1. ___ more energy
2. ___ weight loss
3. ___ sleep better
4. ___ increase sex drive/performance
5. ___Feel and look younger
6. ___mood improvement
7. ___memory improvement
8. ___concentration improvement
9. ___motivation improvement
10. ___digestive function improvement
11. ___quite for life time _Suboxone _Pain med _ Benzo (Klonopin, Clonazepam, Xanax, Valium, etc.) _ADD/ADHD med _Alcohol _Methadone
12. ___control _Anxiety _Depression _ ADD/ADHD _ OCD
13. ___prevent/improve _neurologic degenerative condition
14. ___prevent/improve _cardiac dysfunction
15. ___ improve/maintain sports performance/endurance
16. ___improve_____