OPAL Medical Clinic

Self Administered Evaluation Form

Thank you for taking the time to fill this form, and it will aid the physician in determining your preventive therapeutic plan for optimal aging.

Your name
Chronological Age
Address
Phone
Fax
E-mail

What are your personal goals for this program? (Please describe)

Disease prevention & longevity
Hormonal assessments for andropause & treatments
Hormonal assessments for menopause & treatments
Memory & cognitive assessments & treatments
Osteoporosis & joints assessments & treatments
Cardiovascular health assessments & treatments

Oxidative stress (Vitamin use) assessments & treatments
Sexual Dysfunction assessments & treatments
Cholesterol, blood pressure, diabetes screenings & treatments
Weight loss & nutritional programs
Exercise counseling & tailored programs

Are there any other issues that you want us to address?

(Please note that we may have to refer you to other specialists, if the problem falls outside our scope)

Please tell us more about yourself:

Do you smoke, and how much?
Do you drink, and how much?
Have you done drugs before?
What do you think is your ideal body weight?
How often do you ***exercise*** in a week? Please describe your exercise routine
What kind of work do you do?

Are you allergic to any drugs? Yes ☐ No ☐
Name of drug:

Current prescription medications:
Current vitamins & supplements & dosage:

Tell us about your past medical history:

High Blood Pressure	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐
High Cholesterol	Yes	☐	No	☐
Heart Attack	Yes	☐	No	☐
Surgery	Yes	☐	No	☐
Hospitalizations:	Yes	☐	No	☐
Clinical Depression:	Yes	☐	No	☐

Describe: _____

For Women:
Menstrual history, Menopause, Children, Contraception, Mammogram, PAP smear
For Men:
Last prostate examination, self-testicular examination, erectile dysfunction problems

If you are a **male** over the age of 40 years, please also complete the St. Louis University Andropause (ADAM) Questionnaire				
1. Do you have a decrease in libido?	Yes	☐	No	☐

2. Do you have a lack of energy?	Yes ☐	No ☐		
3. Do you have a decrease in strength and/or endurance?	Yes ☐	No ☐		
4. Do you have a decreased enjoyment of life?	Yes ☐	No ☐		
5. Are you sad?	Yes ☐	No ☐		
6. Are you grumpy?	Yes ☐	No ☐		
7. Are your erections less strong?	Yes ☐	No ☐		
8. Noticed a recent deterioration in your ability to play sports?	Yes ☐	No ☐		
9. Are you falling asleep earlier after dinner?	Yes ☐	No ☐		
10. Has there been a recent deterioration in your work performance?	Yes ☐	No ☐		

If you are **female** over the age of 40 years, please also answer the following OPAL Menopause questionnaire:

1. Change in the length, flow or frequency of your menstrual cycle?	Yes ☐	No☐		
2. Do you suffer from hot flashes?	Yes ☐	No ☐		
3. Do you have night sweats & insomnia	Yes ☐	No ☐		
4. Do you have mood swings	Yes ☐	No ☐		
5. Do you have problems with your memory or concentration?	Yes ☐	No ☐		
6. Has sexual intercourse become uncomfortable because of dryness?	Yes ☐	No ☐		
7. Have you lost interest in sexual activities or libido?	Yes ☐	No ☐		
8. Did your mother undergo menopause at the same age?	Yes ☐	No ☐		
9. Did you have a hysterectomy?	Yes ☐	No ☐		
10. Are you opposed to hormonal replacement?	Yes ☐	No ☐		

We need to take a diet history of what you ate in the **past 3 days** prior to you filling this form:
(Please include portion size)

	Breakfast	Mid Morning	Lunch	Mid Afternoon	Dinner	After Dinner	Drinks: Sodas, Alcohol, etc.
Yesterday							
2 days ago							
3 days ago							

Please tell us about your **family longevity history**:

(Please answer as best as you can, and omit if you are unsure)

	Present Age	Age Died	Diabetes	Blood Pressure	Heart Disease	Cancer	Alzheimer's
Father							
Father's father							
Father's mother							
Father's brother 1							
Father's brother 2							
Father's sister 1							
Father's sister 2							
Mother							
Mother's father							
Mother's mother							
Mother's brother 1							
Mother's brother 2							
Mother's sister 1							
Mother's sister 2							

