# LIVEAGELESSLY

PH: 702-546-5483 FX: 702-252-3000
8605 S. Eastern Ave Suite C, LV, NV 89123

## Medical Update

Thank you for choosing LiveAgelessly!!

In order to serve you properly, we need the following information updates. Please print. **ALL** information will be confidential.

Date: ________________ Patient Name: _____________________________________Birthdate: ___________________

Preferred Contact Phone Number: _____________________________________

Address: _______________________________City: ______________State: _____ Zip: _________

- Address Unchanged

Email: _________________________________________________

**1.) Medical Changes Since Last Year**: **No Changes: ___**

____________________________________________________________________________________________

____________________________________________________________________________________________

**2.) Surgical Changes Since Last Year:** **No Changes: ___**

____________________________________________________________________________________________

____________________________________________________________________________________________

**3.) Medication/Supplement List:** **None: ___**

List all medications/supplements that you take with dose and timing:

Drug Dose Frequency Reason for Medication

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**4.) Allergies: List all adverse/allergy reactions you have to medications** **None: ___**

Medication Name Reason (examples: shortness of breath, hives, rash, upset stomach)

____________________________________________________________________________________________

____________________________________________________________________________________________

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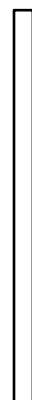
**5.)** **Female**

Last Pap: ________________

Last Mammo (>40):_________________

Last Colonoscopy (>50):_______________



**Male**

Last Prostate Exam:

Last Colonoscopy (>50): ___________

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Las Vegas, NV 89123
Phone: (702)546-5483

NAME:______________________________DATE OF BIRTH:__________________TODAY'S DATE:_______________

**MENOPAUSE RATING SCALE (MRS)**

**Which of the following symptoms apply to you at this time?** (***CHECK ONE BOX & CIRCLE APPLICABLE DESCRIPTION***).

| **Symptoms:** **Rating Scale:** | **NONE** | **MILD** | **MODERATE** | **SEVERE** | **EXTREMELY SEVERE** |
|---|---|---|---|---|---|
| **1) Hot Flashes:** A. Episodes of Sweating B. Night Sweats………………… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **2) Heart Discomfort:** A. Unusual Awareness of Heart Beat B. Heart Racing C. Tightness D. Heart Skipping………………………………… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **3) Sleep Problems:** A. Difficulty In Sleeping Through The Night B. Waking Up Early | ☐ | ☐ | ☐ | ☐ | ☐ |
| **4) Depressive Mood:** A. Feeling Down B. Sad C. On The Verge Of Tears D. Lack of Drive E. Mood Swings…………………………………. | ☐ | ☐ | ☐ | ☐ | ☐ |
| **5) Irritability:** A. Feeling Nervous B. Inner Tension C. Feeling Aggressive………………………………………….…....… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **6) Anxiety:** A. Inner Restlessness/Anxious B. Panicky……………………..….…. | ☐ | ☐ | ☐ | ☐ | ☐ |
| **7) Physical & Mental Exhaustion:** A. General Decrease In Performance B. Impaired Memory C. Decrease in Concentration D. Brain Fog/Forgetfulness……………….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| **8) Sexual Health:** A. Lack Of Desire B. Change In Activity C. Change in Satisfaction………………………….………….…… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **9) Vaginal Health:** A. Dryness Of Vagina B. Difficulty With Intercourse C. Dryness Or Burning During Intercourse…………………......……… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **10) Bladder Problems:** A. Difficulty Urinating B. Increased Need To Urinate C. Bladder Incontinence…………………………...….…………… | ☐ | ☐ | ☐ | ☐ | ☐ |
| **11) Musculoskeletal:** A. Joint Discomfort/Pain B. Muscular Discomfort/Pain C. Rheumatoid Discomfort/Pain……………………....………….. | ☐ | ☐ | ☐ | ☐ | ☐ |

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**FOR OFFICE USE ONLY**

Please circle which applies to THIS questionnaire. **Baseline** or **Follow-Up**

**Baseline** ☐ **No hormone Therapy** ☐ **Hormone Therapy (Other than Pellet Therapy)** ☐

**Testosterone Pellet Dose**_______________________ **Date Implanted**_____________________________

**Additional Hormone Therapy**____________________________________ **Date Started**________________

**Pre-Menopausal** ☐ **Post-Menopausal** ☐ **Partial Hysterectomy** ☐ **Total Hysterectomy** ☐