

Annual Evaluation

To help ensure that your ongoing **Maintaining Wellness Phase** continues to keep you well and support your health goals, it’s important that we evaluate your health progress once a year. Your **Annual Evaluation visit** is a special time to review your overall care; what has improved and what still needs attention for your health and well being. We want to help you maintain the positive changes you have gained and optimize your health further with personalized “health tune-up” suggestions.

**You are here \***

**START**

Phase I: Relief

Phase II: Rebuilding

Phase III: Maintenance

Phase IV: Maintaining Wellness

AE

**Health Peaks**

**What to know about your Annual Evaluation visit**

* Schedule a 1-hour visit for your Annual Evaluation. (30 minutes consult */* 30 minutes exam)
(Allow 90 minutes in the office.)
* Schedule a 30 minute visit for your **Report of Findings** — 2weeks after your Annual Evaluation visit. (Allow 45 minutes in the office.)
* Complete and return to us the **Annual Evaluation questionnaire** at least **48 hours** before your visit. (*See the following page for more information and instructions*.)

**On the day of your Annual Evaluation visit**

* When you arrive at our office, please check in with our receptionist, then proceed to our restroom to **leave a urine sample**.Oneof our staff will then direct you to an examroom to get ready for the visit (changing into a gown, etc.)
* **Fasting blood draw**: Please do not consume any food or drink except water for at least 10 hours prior to coming in. **Drinking plenty of water** helps make the blood draw easier. Remember to take your usual early morning medications before coming in.
* **Body composition analysis:** For best results on this exam and during the 24 hours prior to it:
1. Drink at least 6-8 glasses of water.
2. Avoid alcohol and caffeine consumption.
3. Avoid solid foods for at least 4 hours prior to the exam.
4. On the day of the exam, do not exercise.
* Please remove nail polish so the doctor can evaluate your nails during the exam. If you do not wish to remove your fingernail polish, please remove polish from at least one big toenail.



**Annual Evaluation Questionnaire**

**What to know about the Annual Evaluation questionnaire**

This questionnaire is to help you assess your own health progress so far. Getting your feedback is an important part of refining your treatment plan to best meet your needs and health goals. We will evaluate your progress using your questionnaire along with results from nutritional and hormonal exams, consultation, and lab tests. After your **Annual Evaluation** and **Report of Findings** **visits**, we will refine your **Maintaining** **Wellness Treatment Plan** to ensure it helps you get the best results.

* Please complete ALLpages of thisquestionnaire **based on the past year you’ve been in treatment with us** (we’ll compare this questionnaire with the ones you completed earlier).
* Follow the instructions on each page, and answer questions **based on the BEST your body was able to feel during the past year** (i.e., a good day).
* Include your name and date on **every** page.
* **Please return your completed form to us at least 48 HOURS before your Annual Evaluation visit**.

**How to complete and return this questionnaire to us**

1. Complete this form using Microsoft Word. Save the file with a new filename that includes
**your name** using the format **First-Last-WatersEdge-Annual-Evaluation.doc**
(e.g., "Mary-Smith-WatersEdge-Annual-Evaluation.doc").
(NOTE: Please leave the document in MSWord .*doc* format; do not convert it to another format such as HTML.)
2. Returning the form to us: **Option** **A**.) As an email from your patient portal send the attachment.
In the Subject field of the email, write: **Progress Evaluation #2. Option B**.) Mail to 1000 2nd Ave Suite 2920 Seattle WA 98104

**NOTE**: \*\***Please be sure to mail it at least 5 days before your appointment so we receive it 48 hours in advance**.

If you have any questions, please call us at **206. 283. 1383**. Thank you and we look forward to seeing you again!



Annual Evaluation Questionnaire

AE

Name Date

Current Health Condition

(Please list your present health problems and concerns.)

|  |  |
| --- | --- |
| **Problem or Concern** | **Date of Onset** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**1. For your care at this office to be a huge success for you, what do you see happening over the next 3 months, 6 months, 12 months?**

|  |
| --- |
|  |

**2. What has improved with your health and well being since you began treatment with us?**

|  |
| --- |
|  |

**3. What has not improved? Has anything gotten worse?**

|  |
| --- |
|  |

**4. Which foods cause you any stress? List items and what reactions.**

|  |
| --- |
|  |

**5. Please update the information on allergies, hospitalization, surgeries, serious injuries since your last report (dates and types of illness or operation):**

|  |
| --- |
|  |
|  |
|  |
|  |

6. What behavior and lifestyle habits do you need to change in order to improve your health? CHECK the one(s) that is the most important to change.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Exercise |  | Proper sleep and rest |  | Diet and nutrition |
|  | Stress management |  | Mental Attitude |  | Smoking |
|  | Recreational drugs  |  | Alcohol |  | Medications |
|  | Unhealthy occupation |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**7. What do you think is your doctor’s responsibility in your health care?**

|  |
| --- |
|  |

**8. What is your degree of responsibility for your own health?**

|  |
| --- |
|  |

**9. What is your current level of commitment to learn and adopt habits to improve your health?**

(Rate on a scale of 1 to 10): **LOW 🡨1 2 3 4 5 6 7 8 9 10 🡪 HIGH**

**If your level of commitment is low, what do you think it would take to raise it?**

|  |
| --- |
|  |

**10. What specifically would you like to focus on during your Maintaining Wellness Phase?**

|  |
| --- |
|  |

Health Data

**(Please fill in completely)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Exam** | **Date** | **Result** | **Due** | **Screening Recommendations** |
| Last Pap Smear/Gynecologic Exam |  |  |  | Yearly starting after first intercourse or age 21 |
| Mammogram |  |  |  | Yearly starting at age 40 |
| Bone Density Test (DEXA) |  |  |  | Every 2 years starting at age 50 |
| Colonoscopy |  |  |  | Every 10 years starting at age 50 |
| Prostate or Testicular Exam |  |  |  | Yearly for men starting at age 40 |
| **Other** | **Date** | **Location** | **Result** |
| Physical Exam |  |  |  |
| Foreign Travel History & Immunizations |  |  |  |
| Tuberculosis (TB) skin test |  |  |  |
| Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.) |  |  |  |

Name Date

Current Medications

**PLEASE LIST EVERYTHING YOU ARE TAKING NOW**

Include all your current **prescription medications** (sleeping pills, birth controls pills), **non-prescription medications** (aspirin, antacids, laxatives, antihistamines), all medications from this office, and anything else you may be taking such as vitamins, minerals, herbs, etc. (**Include dose for each**.) **\*\*Please place a“✓” next to medications you wish to continue using**.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dose per day** | **Reason for use** |
|  |  |  |  |
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| **Which Medical Food Shakes are you using:** |
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|  |  |  |  |

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| --- |
| **Medications you are NOT using now:** |
|  |  |  |
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|  |  |  |

**Life Style Index**

**Please rate your level of functioning for each area of you life on a scale of 1-10 (10 = best)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Function** | **Rating** | **Function** | **Rating** | **Function** | **Rating** |
| Mental |  | Family |  | Social |  |
| Emotional |  | Creativity |  | Spiritual |  |
| Physical |  | Fun |  | Career |  |

Name Date

Health Update

Please check any of the following that you **currently** **have** or **have** **had in the past month**.

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | **Gastrointestinal** | **Eye/Ear/Nose/Throat** | **Cardiovascular** |
| ¨ Chills¨ Depression¨ Dizziness¨ Fainting¨ Fever¨ Forgetfulness¨ Headache¨ Loss of sleep¨ Nervousness¨ Numbness¨ Sweats | ¨ Poor Appetite¨ Bloating¨ Bowel changes¨ Constipation <1 stool/day¨ Diarrhea¨ Excessive hunger¨ Excessive thirst¨ Gas¨ Hemorrhoids¨ Indigestion¨ Nausea¨ Rectal bleeding¨ Stomach pain¨ Vomiting¨ Vomiting blood¨ Parasites | ¨ Bleeding gums¨ Blurred vision¨ Crosses eyes¨ Difficulty of swallowing¨ Double vision¨ Ear ache¨ Ear discharge¨ Hay fever¨ Hoarseness¨ Loss of hearing¨ Nosebleeds¨ Ringing in the ears¨ Sinus infections¨ Vision “flashes”¨ Vision “halos” | ¨ Chest pain/pressure¨ High blood pressure¨ Irregular heart beats¨ Low blood pressure¨ Poor circulation¨ Rapid heart beat¨ Varicose veins¨ Edema |

|  |  |  |  |
| --- | --- | --- | --- |
| **Respiratory** | **Skin** | **Muscle/Joint/Bone** | **Genito-Urinary** |
| ¨ Shortness of breath¨ Persistent cough¨ Wheezing¨ Cough with blood | ¨ Acne¨ Bruise easily¨ Itching¨ Change in mole(s)¨ Rash¨ Scars¨ Sore that won’t heal | Pain, weakness, numbness in:¨ Arms¨ Back¨ Feet¨ Hands¨ Hips¨ Legs¨ Neck¨ Shoulders¨ Loss of height | ¨ Blood in the urine¨ Frequent urination¨ Lack of bladder control¨ Painful urination |

Name Date

**Vitality Survey**

**Scoring: Never —0 Seldom — I Occasionally —2 Often —3 Very Often —4**

|  |  |
| --- | --- |
| **How often do you…**  | **Score** |
| Lose your sense of humor/take life too seriously? |  |
| Experience doubt or indecision? |  |
| Experience worry and anxiety? |  |
| Feel over-cautious or pessimistic? |  |
| Lack self confidence or feel low self-esteem? - |  |
| Experience stress or feel nervous or tense? |  |
| Feel irritable or oversensitive? |  |
| Experience difficulty concentrating and loss of clear thought? |  |
| Experience inadequate energy (fatigue)? |  |
| Have coffee, tea, tobacco, sugar or other stimulants as a pick up? |  |
| Experience nervous indigestion? |  |
| Experience loss of sex drive? |  |
| Experience difficulty sleeping? |  |
| Experience difficulty getting up in the morning? |  |
| Feel run down? |  |
| Feel depressed? |  |
| Feel like crying for no reason? |  |
| Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)? |  |
| Find it difficult to express your feelings? |  |
| Experience rapid heart beat or panic? -. |  |
| Feel moody? |  |
| Feel suicidal or wonder whether life is worth living? |  |
| Have anxiety about not having enough money? |  |
| Fear ill health? |  |
| Fear criticism? |  |
| Fear loss of love? |  |
| Fear old age or death? |  |
| Feel “something is the matter with me” but don’t know what? |  |
| Think that you might be going crazy (losing it)? |  |
| **TOTAL SCORE:** |  |

|  |  |
| --- | --- |
| 0 — 30 POINTS = Powerful Nerve Force HIGH VITALITY31— 45 POINTS = Strong Nerve Force GOOD VITALITY46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY61 — 75 POINTS = Low Nerve Force LOW VITALITY | 76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION106 — 120 POINTS = Serious Nervous Exhaustion SEVERE BURNOUT |

Name Date

**Female Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **if it’s present** by rating it on a **Wellness Gauge Scale** **0 to 10
when 0 = symptom is not present ☺ and 10 = symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Fibroids |  | Mood swings |
|  | Allergies |  | Fluid retention |  | Night sweats |
|  | Anger easily |  | Food cravings/binge eating |  | Ovarian cyst(s) |
|  | Back pain |  | Heavy menstrual bleeding |  | PMS |
|  | Bloating |  | Vaginal dryness |  | Rheumatoid arthritis |
|  | Chronic stress |  | Hot flashes |  | Skin problems |
|  | Depression |  | Insomnia |  | Spotting |
|  | Disinterest in sex/low sex drive |  | Irregular menstrual cycle |  | Subfertility |
|  | Endometriosis |  | Irritable or anxious |  | Other: |
|  | Fatigue |  | Meat eater (rate frequency) |  |  |
|  | Fibrocystic breast disease |  | Menstrual migraines |  |  |
|  | **TOTAL SCORE:** |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Ovarian Cancer |  | Infertility (never able to conceive) |
|  | Uterine Cancer |  | Loss of height/ bone loss |
|  | Cervical Cancer |  | Miscarriage |
|  | Breast Cancer |  | Premature menopause (<45 yrs old) |
|  | Estrogen/Progesterone sensitive Cancer |  | Pain with intercourse |
|  |  |  | **TOTAL SCORE:** |
|  | **GRAND TOTAL SCORE:** |

|  |
| --- |
| **Are you completely satisfied with your sexual experience:** Yes\_\_\_\_ No \_\_\_\_ |
| Please explain: |
|  |
|  |

Name Date

**Men Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Breast lump |  |  | DES – did your mother take it during pregnancy? |  |  |
| Lump in testicle |  |  | Date of last genital exam: |  |  |
| Penis discharge  |  |  | Date of last prostate exam: |
| Sore on the penis  |  |  | Date of last PSA test: Result: |
| Erection difficulties  |  |  |  |

**Male Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **when it’s present** by rating it on a **Wellness Gauge Scale 0 to 10,
when 0= symptom is not present ☺, 10= symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Thinning armpit, head, pubic hair |  | Urine flow dribbling at the end |
|  | Joint pain/Stiffness |  | Skin problems/dryness |  | Blood in urine |
|  | Anger easily |  | Excessive sweating (day or night)  |  | Urinary incontinence |
|  | Back pain |  | Mood swings |  | Pain with urination |
|  | Rheumatoid arthritis |  | Lack interest in leisure/social activities |  | Pain with ejaculation |
|  | Chronic stress |  | Low stamina |  | Bloody ejaculation |
|  | Depression |  | Difficulty obtaining erection |  | Pain with intercourse |
|  | Disinterest in sex/low sex drive |  | Difficulty maintaining erection |  | Unable to conceive (subfertility) |
|  | Erectile dysfunction |  | Pain with erection |  | Mass in genital organs |
|  | Fatigue |  | Lack of nocturnal erections |  | Heavy drinking (past/ present) |
|  | Insomnia |  | Lack of morning erections |  | Frequent urination  |
|  | Irritable or anxious |  | Urine flow slow to start |  | Other: |
|  | Food cravings/binge eating |  | Weak urine stream |  |  |
|  | Breast enlargement |  | Unable to void bladder completely |  |  |
|  | **TOTAL SCORE:** |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | History of mumps infection |  | Infertility (never able to conceive) |
|  | History of mass in genitalia |  | Loss of height/bone loss |
|  | History of testicular/scrotal surgery |  | Cancer: (list type) |
|  | Developmental issues w/sex organs |  | Other: |
|  | Family history of prostate cancer |  | **TOTAL SCORE:** |
|  | **GRAND TOTAL SCORE:** |