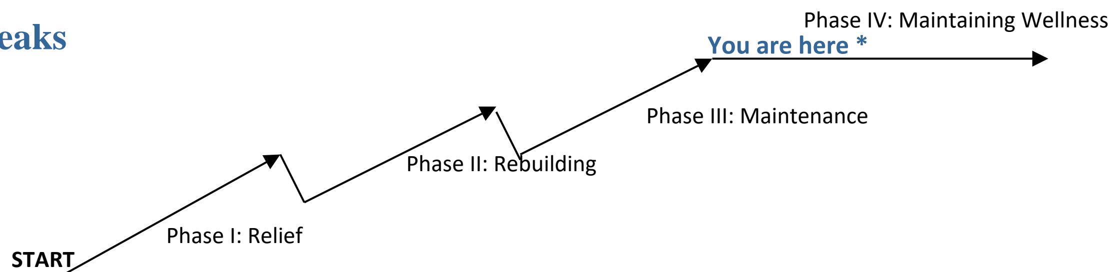
Water's Edge
NATURAL MEDICINE

Annual Evaluation

AE

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.

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** — 2 weeks 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**. One of our staff will then direct you to an exam room 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 ALL pages of this questionnaire **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. Return the form to us by mail to: **3131 Elliott Ave, Suite 740, Seattle, WA 98121**
   or by fax: **206-283-1924**

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!

Water's Edge
NATURAL MEDICINE

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 <u>continue using</u>.**

	Medication	Dose per day	Reason for use

	Which Medical Food Shakes are you using:		

Medications you are NOT using now:		

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

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

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 VITALITY 31— 45 POINTS = Strong Nerve Force GOOD VITALITY 46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY 61 — 75 POINTS = Low Nerve Force LOW VITALITY	76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE 91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION 106 — 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: