Live Agelessly
8605 S. Eastern Ave. Suite #C
Las Vegas, NV 89123
Ph: 702-546-5483

NAME:_____ DOB:_____ DATE:_____

AMS QUESTIONNAIRE

Which of the following symptoms apply to you at this time? Please mark the appropriate box for each symptom. For symptoms that do not apply please mark 'NONE"

Symptoms:	NONE	MILD	MODERATE	SERVERE	EXTRMELY SEVERE
SCORE =	1	2	3	4	5
1. Decline in your felling of general well being (General state of health, subjective feeling)……	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, Joint pain, pain in a limb, general backache)……	☐	☐	☐	☐	☐
3. Excessive sweating (unexpected/sudden episodes of Sweating, hot flashed independent of strain)……	☐	☐	☐	☐	☐
4. Sleep problems (difficulty in falling asleep, difficulty in Sleeping through, waking up early and feeling tired, poor Sleep, sleeplessness)……	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired……	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little Things, moody)……	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)……	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky)……	☐	☐	☐	☐	☐
9. Physical exhaustion/lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done or achieving less of having to force one self to undertake activities)……	☐	☐	☐	☐	☐
10. Decrease in muscular strength (feeling of weakness.)……	☐	☐	☐	☐	☐
11. Depressive mood (Feeling down, sad, on the verge of tears, Lack of drive, mood swings, feeling nothing is of any use)……	☐	☐	☐	☐	☐
12. Felling that you have passed your peak ……	☐	☐	☐	☐	☐
13. Felling burnt out, having hit rock bottom……	☐	☐	☐	☐	☐
14. Decrease in beard growth……	☐	☐	☐	☐	☐
15. Decrease in ability/frequency to preform sexually……	☐	☐	☐	☐	☐
16. Decrease in the number or morning erections……	☐	☐	☐	☐	☐
17. Decrease in sexual desire/libido (lacking please of sex, lacking Desire for sexual intercourse) ……	☐	☐	☐	☐	☐

Do you have any other major symptoms? Yes……☐ No……☐
If yes, please descirbe:_____

Recent PSA: _____ Date_____ Digital rectal exam, date: _____

PRIOR PSA's DATE:_____ Please list all history or prostate problems_____

Baseline_____ Week4_____

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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:_____

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 Reaction (examples: shortness of breath, hives, rash, upset stomach)

_____
_____
_____
_____

5.) <u>Female</u>

Last Pap:_____
Last Mammo (>40):_____
Last Colonoscopy (>50):_____
Last Menstrual Cycle:_____

<u>Male</u>

Last Prostate Exam:_____
Last Colonoscopy (>50): _____

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LAB WORK WAIVER

Labs are ordered at your first visit. After which all labs are ordered prior to your appointments. Please make every effort to have them done in time so that your treatment plan can be initiated. Once your results are in, someone from LiveAgelessly will call and schedule your appointment.

We make no guarantees that the labs ordered by our office will be covered by insurance & LiveAgelessly will not correspond with your insurance company or the laboratory. In order to avoid high laboratory fees we recommend using our preferred laboratory, True Health Diagnostics. We also encourage all our patients to know their laboratory benefits before any lab work is drawn.
*Please keep in mind that there is a $25 fee for all replacement lab slips.

I understand that LiveAgelessly is not responsible for any laboratory expenses and does not guarantee that lab work will be covered by insurance.

Signature: _____ **Date:** _____

LA

LiveAgelessly

8605 S. Eastern Ave Suite C1
Las Vegas, NV 89123

PATIENT INFORMATION

Thank you for choosing LiveAgelessly! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Check appropriate box: □Minor □Single □Engaged □Married □Separated □Divorced □Widowed

Gender: □Male □Female □Transgender

Patient Name: _____Birthdate:_____
Home Ph: _____Cell Ph: _____SSN:_____
Address: _____City:_____State:_____Zip: _____
Patient's employer: _____Work:_____Phone:_____
Business address: _____City: _____State: _____ Zip: _____
Patient Occupation: _____
Spouse/Partners name: _____
Employer: _____ Work: _____Phone:_____
Whom may we thank for referring you? _____
Person to contact in case of emergency: _____
Relation: _____ Phone: _____
Personal Email _____

Once available, would you like to receive the *LiveAgelessly* newsletter with health-related articles, information about upcoming seminars and workshops, and patient-only special events?

□Yes □No

Dr. Keller and the staff at *LiveAgelessly* are committed to maintaining the privacy of our clients' Protected Health Information, while providing high quality service. Please acknowledge by signing below that you are aware of our NOTICE OF PRIVACY PRACTICES. A photocopy can be furnished to you upon request.

I UNDERSTAND THAT *LIVEAGELESSLY* IS NOT CONTRACTED WITH AND THEREFORE DOES NOT BILL INSURANCE COMPANIES AND THAT I AM RESPONSIBLE FOR ALL FEES AND THAT ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

X_____

SIGNATURE **DATE**