

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Best phone number to contact you at: (\_\_\_\_)-(\_\_\_\_)-\_\_\_\_\_ this is  home  work  cell

Fax number: \_\_\_\_\_ e-mail address \_\_\_\_\_

Sex  M  F Age:  35-45  45-55  55-65  65-75  75+

Instructions:

Please place an "X" next to the answer that best represents your response.

**1. I am concerned about preserving a high quality of life as I get older.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**2. I am concerned about maintaining a youthful (or younger) appearance.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**3. I am concerned about being able to stay physically active as I get older.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**4. I am concerned about maintaining or regaining a satisfying intimate relationship.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**5. I am concerned about a family history of disease and/or disability.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**6. I am concerned about conflicting opinions regarding maintaining health and wellness as one ages.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**7. I am concerned about the potential costs of ill health later in my later years that could eat away at my savings.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**8. I am concerned about with the possibility of being uninsurable at some point in the future.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**9. I am concerned about my ability to stay mentally focused and productive as I get older.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

**10. I am concerned about doing something that will positively impact my life as I age.**

Not at all  Somewhat  About average level of concern  Very concerned  Extremely concerned

I'm also concerned about/interested in: \_\_\_\_\_

\_\_\_\_\_

**Jan V. Karlin, MD**  
**Anti-Aging Program**  
**Initial Patient Questionnaire**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

On a scale of 1-10 please rate where you think you are currently in the following areas with 10 being the best. Mark N/A if the question does not apply to you.

<b>Areas to Be Evaluated</b>	<b>Rating 1-10</b>
<b>STRENGTH, EXERCISE AND BODY FAT;</b>	
Muscle Strength	_____
Muscle Size	_____
Body Fat	_____
Exercise Tolerance	_____
<b>SKIN AND HAIR:</b>	
Skin Texture	_____
Skin Thickness	_____
Skin Elasticity	_____
Wrinkles	_____
New Hair Growth	_____
<b>HEALING, FLEXIBILITY, RESISTANCE:</b>	
Healing of Old Injuries	_____
Healing of Other Injuries	_____
Healing Capacity	_____
Back Flexibility	_____
Resistance to Common Illness	_____
<b>SEXUAL FUNCTION:</b>	
Sexual Potency	_____
Duration of Penile Erection	_____
Frequency of Night Time Urination	_____
Hot Flashes	_____
Menstrual Cycle Regulation	_____
<b>ENERGY, EMOTIONS, MEMORY:</b>	
Energy Level	_____
Emotional Stability	_____
Attitude Toward Life	_____
Memory	_____

*Side Effects: joint pain, swelling, tingling or other. Please specify:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Jan V. Karlin, MD**  
**Anti-Aging Program**  
**Supplemental Health Questionnaire**

Please answer the following questions:

1) What is your current weight? \_\_\_\_\_ Height? \_\_\_\_\_

Maximum weight \_\_\_\_\_ Minimum weight? \_\_\_\_\_

2) What is your percent body fat? (required) \_\_\_\_\_

3) What is your family's history of cancer? \_\_\_\_\_

4) Are both parents still alive? Mother \_\_\_ Father \_\_\_ How old: Mother \_\_\_ Father \_\_\_  
If not, age and cause of death \_\_\_\_\_

5) If you take any of the following please list names:

Vitamins \_\_\_\_\_

Herbs \_\_\_\_\_

Supplements \_\_\_\_\_

Hormones \_\_\_\_\_

Hormones (taken in the past) \_\_\_\_\_

6) Please describe your daily activity/exercise program. (resistance, walking, aerobics, other): \_\_\_\_\_

How many times a week? \_\_\_\_\_

7) When was your last physical exam? \_\_\_\_\_

mammogram? \_\_\_\_\_

pap smear? \_\_\_\_\_

prostate exam? \_\_\_\_\_

8) What are your current eating habits? (Do you eat junk food, vegetarian, etc.)  
\_\_\_\_\_

9) Do you practice stress reduction? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, how? \_\_\_\_\_

This information is accurate to the best of my knowledge.

Patient \_\_\_\_\_

Date \_\_\_\_\_

## **Consent for Hormone Supplementation Therapy**

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by Jan V. Karlin, MD. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me..

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

*I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.*

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that the role of the physician is for hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understand all of the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Physician Signature

\_\_\_\_\_

Date