Regenesis MD

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Anti-Aging Questionnaire

Patient Name:_____ Patient DOB:_____ Date:_____

Please answer the following questions to the best of your ability. Please feel free to put "Y" for "yes" and "N" for "no"

1) Is fatigue a problem for you? _____
2) Are you tired throughout the day? _____
3) How many hours of sleep do you get a night? _____
4) Do you have trouble falling asleep? _____
5) Trouble staying asleep? _____
6) Are you tired in the mornings? _____
7) Do you have to drink caffeine to feel energized? _____
8) Do you have to take supplements to feel energized? If so, which ones?
   _____
9) Do you feel like you can't exercise or play sports like you used to?
   _____
10) Does it take you longer to recover from a workout? _____
11) Do you feel like memory is a problem for you? _____
12) Are you forgetful? _____
13) Do you have trouble focusing/concentrating? _____
14) Do you have trouble completing tasks? _____
15) Do you feel like your life is stressful? _____
16) Use 1-2 words to describe your overall mood? _____
17) Do you have mood swings? _____
18) Do you struggle with having "enjoyment in life"? _____
19) Do you have a good "work-life balance"? _____
20) Is your sex drive lower than it used to be? _____
21) Are you and your partner fulfilled when it comes to your sex life? _____
22) Do you enjoy sex? _____
23) Is sex painful? _____
24) Are you able to orgasm? _____

25) Males only: Do you have trouble getting or maintaining an erection? _____
26) Is weight an issue for you? _____
27) Have you recently lost weight? _____
28) Have you recently gained weight? _____
29) Do you exercise? If so, how much and what type? _____
30) Have you experienced a decrease in or inability to maintain muscle mass? _____
31) Have you tried any programs or medications to help lose weight? If so, which ones? _____
32) Do you feel like you eat a well balanced diet? _____
33) Are you happy with the way you eat? _____
34) Do you have an issue controlling cravings? _____
35) Do you have trouble feeling full? _____
36) Do you eat more when you are stressed? _____
37) Have you had any recent changes in your stool? _____
38) Do you struggle with constipation? _____
39) Do you struggle with diarrhea? _____
40) Are you bloated? _____
41) Do you have any food allergies or intolerances? _____
42) Do you feel like you have trouble digesting certain foods? If so, which ones? _____