Sarah Sandell, M.D., F.A.C.P. and Susan Sleep, M.D.
A Medical Corporation
3742 Katella Ave., Suite 302
Los Alamitos, CA 90720
562-936-0292 FAX 562-936-1943

Dear Patient,

You have been scheduled for an annual exam. At that time I will be doing a yearly check up which includes taking a thorough medical history and performing a physical exam. Please make sure you take the time to completely fill out the history form and pay special attention to the form for medications and supplements including dosages (**Fill this out in detail).** If you have any medical records from other offices which are helpful please bring them in or have them sent to our office.

At this appointment we may do blood tests, some of which may require you to be fasting (nothing to eat for 8 hours before the test). If you have a morning appointment and can come fasting that is helpful otherwise you might need to return another day for blood tests.

In order to provide the best Integrative Medical care, after any tests including blood tests are performed, I will then ask you to return for a follow up appointment to review the results. At that time I will also ask you to bring in any vitamins and supplements you are taking so I can make specific recommendations re: this as well as your diet and other lifestyle issues. I believe you can have a positive impact on your health through proper nutrition, lifestyle and appropriate supplements. Enough time needs to be set aside to address these issues.

Please be sure to bring insurance card with you for updating our records. If you have Medicare you would be considered a 'cash patient' for office visits as we have "Opted Out" of Medicare. Laboratory fees, imaging fees, and hospital charges are not affected as most are contracted with Medicare. If you have further questions you may contact our office.

If you have any questions please give our office a call otherwise I'll look forward to seeing you.

Sincerely,

Sarah Sandell, F.A.C.P., M.D.
Graduate Fellow, Integrative Medicine, University of Arizona
Assistant Clinical Professor of Medicine UC.L.A., School of Medicine

FirstLineTherapy®

What is a BIA?
(And why do you need one?)

Bioelectrical Impedance Analysis or Bioimpedance Analysis (BIA) is a method of assessing your "body composition"—the measurement of body fat in relation to lean body mass. It is an integral part of a health and nutrition assessment.

Improving your BIA measurement by lowering your percentage of unhealthy body fat can help reduce your risk to a variety of serious health conditions.

Why is Body Composition Important to My Health?

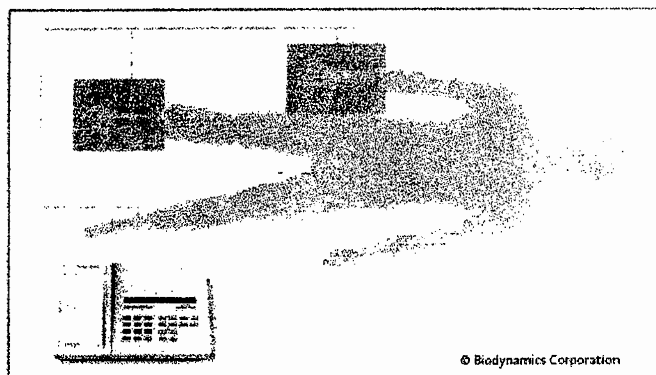
Research has shown that body composition is directly related to health. A normal balance of body fat is associated with good health and longevity. Excess fat in relation to lean body mass, a condition known as altered body composition, can greatly increase your risks to cardiovascular disease, diabetes, and more. BIA fosters early detection of an improper balance in your body composition, which allows for earlier intervention and prevention. BIA also provides a measurement of fluid and body mass that can be a critical assessment tool for your current state of health.

BIA also serves to measure your progress as you work to improve your health. Improving your BIA measurement, or maintaining a healthy BIA measurement, can help keep your body functioning properly for healthy aging and reduced risk to illness. With your BIA results, we can recommend a personalized dietary plan, nutritional supplements, and exercise to help you support optimal health and well-being for a lifetime.

How Does a BIA Work?

BIA is much more sophisticated than your bathroom scale, but just as painless—and almost as quick. BIA is a simple procedure that can be performed right in our office in a matter of minutes with the help of a sophisticated, computerized analysis.

This analyzer "calculates" your tissue and fluid compartments—using an imperceptible electrical current passed through pads placed on one hand and foot as you lie comfortably clothed on an exam table. In just minutes, we'll have very accurate measurements to help create an effective, personalized program to improve your health status.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Body Composition Testing

Bioimpedance analysis (BIA) is a reliable method of measuring body composition, including percentage of body fat and lean body mass. Measurements are taken with a bioimpedance analyzer, which uses electrodes similar to EKG electrodes. The machine passes a harmless, ultra-low level electrical current through the body. Lean tissue, which is over 70% water, is a good conductor of electrical current. Fatty tissue—low in water, is not. Thus, the resistance to the flow of electrical current measured by the analyzer can be used to calculate body composition.

Participants will need to remove their right shoe and sock or stocking. The electrodes are placed on the right hand and foot while the individual is lying down on an exam table. This whole procedure takes only a few minutes and a computer prints out the results. Optimal body fat ranges from 12%-25% for women, and 5%-20% for men.

Over 100 independent studies, conducted by researchers over the past 20 years, have demonstrated that bioimpedance analysis can provide an accurate and clinically useful assessment of body composition. However, for the most accurate results, the following guidelines should be followed:

1. **Do not eat for 4 hours prior to testing.**
2. **Do not exercise for 12 hours prior to testing.**
3. **Do not consume alcohol for 24 hours prior to testing.**
4. **Drink at least 1 quart of water one hour before your test (you may void as needed).**
5. **Do not drink caffeine the day of your test.**

IF YOU ARE INTERESTED IN HAVING THIS TEST DONE PLEASE FOLLOW THESE GUIDELINES BEFORE YOUR APPOINTMENT. ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED APPPOINTMENT TIME AND NOTIFY THE STAFF WHEN YOU ARRIVE YOU WANT TO HAVE THE TEST DONE.

THE COST OF THE TEST IS $75 AND MAY NOT BE COVERED BY YOUR INSURANCE

MEDICAL HISTORY PLEASE UPDATE/PROVIDE INFORMATION SINCE YOUR LAST PHYSICAL

NAME_______________________________ DATE OF BIRTH___________ TODAYS DATE_______

Please fill out **completely** and provide details requested. Use a 3rd page if needed to answer any questions or provide additional information on issues you wish to discuss today.

Please describe any medical problems <u>you wish to discuss at this visit</u>

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____

Have there been any significant changes in your health since your last physical that we may not be aware of? If so please describe:____

____

____

Current Medications - **PLEASE FILL OUT A SEPERATE FORM IN DETAIL LISTING PRESCRIPTION MEDICATION AND SUPPLEMENTS. It is important to fill this out with ALL the information.**

Have there been any new allergic reactions/ side effects to medication/ food/supplements since your last physical. If so, please describe the reaction (ex. rash)

____

____

____

____

Social History/Other information Ethnicity ______________________________

Marital status___________ Occupation______________________ Who lives with you_______________

What pets do you have at home? ____

Do you smoke cigarettes if so how much ________________________ if quit, when_____________

Have you used any recreational/illicit drugs?____

How much alcohol do you drink?____

How much caffeine containing beverages do you drink? ______________________________________

How much water do you drink?____

Describe your current exercise activities____

Describe your current diet **in detail**

Breakfast ____

Lunch____

Dinner____

Snacks____

Please note the date if you have had any of the following tests at another facility since your last physical:

Colonoscopy ___________ **Pap smear**____________ **Rectal exam/Prostate exam**____________

Mammogram___________ **Breast exam by a health care provider**___________ **PSA**___________

Bone density scan______________ **Eye exam** ___________ **Dental exam** ___________

Other____

FAMILY HISTORY: Please provide any new information which has occurred since your last physical.

____

____

____

____

Name_______________________________ D.O.B.__________________ Date______________________
Please check if you are having a problem with any of the following now:

Fever____ Chills____ Fatigue____ Night sweats_____ Hot flush____ Weight loss____ Weight gain____
Changes in hair____ Weakness____ Rash____ Dry skin____
Changes in nails_____ Itching_____ New skin growths or changes of concern__________________

Visual disturbance____ double vision____ Glaucoma____ Cataracts____ Eye pain____ Hearing loss____
Ringing in your ears____ ear pain____ Nasal congestion____ Nose bleeds____ Sinus problems____
Problems with your teeth/gums____ Hoarseness____ Sore throat____ Snoring_____
Neck pain____ Swollen "glands"____ Difficulty swallowing____ Thyroid problems____
Other problems with your eyes, ears, nose, throat, neck_____________________________________

Breast pain____ Breast lumps____ Nipple discharge____ Other breast problems____________________

Cough____, Excessive or bloody sputum____ Wheezing____ Asthma____ Bronchitis____ Pneumonia_____
Other problems with your lungs/breathing____

Palpitation____Arrythymia ____ Edema____ Shortness of breath (at rest or with exertion)____
Valvular heart disease____ Other heart problems____

Leg pain/cramps_____ Phlebitis____ Back Pain____ Neck Pain____ Hip pain____ Groin pain____
Knee pain____ Arm or shoulder pain____Arthritis____ Gout____ Other musculoskeletal problems__________

Heartburn/indigestion____ change in appetite____ Nausea or vomiting____ Change in bowel habits ______
Constipation____ Diarrhea____ Blood in your stool ____ Black stools ____ Hepatitis____
Irritable bowel____ Colitis____ Gallstones____ Liver disease____ Hemorrhoids____ Abdominal pain____
Food intolerance____ History of Ulcer disease____Other intestinal problems_________________

Anemia____ Excessive bleeding/bruising____ History of blood clots____ Other blood disorder____________

History of diabetes____ Excessive thirst or urination____ Intolerance to heat or cold____
Anxiety____ Depression____ Difficulty sleeping____ Other mood disturbance_______________________
Fainting____ Dizziness____ Seizure____ Stroke____ Tremors____ Localized weakness or numbness____
Problems with memory____ Headache_____Other neurologic problems_____________________________

Urinary frequency/urgency____ Incontinence____ Urinary tract infection____ Blood in urine___
Kidney stones___ Other problems urinating or change in urination_____________________________
History of a sexual transmitted disease if so, describe____
Problems with sexual desire or function____
Number of sexual partners in the past few years_____ Men / Women / Both_____
Females: Vaginal discharge____ Pain with intercourse____ Other problems____________________
If still menstruating: My period occurs every _____ days and lasts for ____ days.Are your periods regular?
Yes/no ____Heavy Yes/no_____ Bleed in between actual period Yes/no____;severe cramps Yes/no___
check here if no longer having menstrual periods____; #of previous pregnancies___ Miscarriage/Abortion ___
Males: Pain in testicles/penis____ Penile discharge____ Prostate problems____ Other problems_________
Difficulty obtaining or maintaining an erection_____

Do you have a power of attorney for health care or advanced directives (ex. Living will)________________
Do you practice any relaxation techniques (ex. Meditation)_____________________________________
Do you have any spiritual beliefs, if so please describe____

NAME ______________________________ DATE ____/____/____

NAME OF MEDICATION/ VITAMINS/SUPPLIMENTS	DOSE (mg)	TIME taken	REASON TAKING	DR (who prescribed it)