



Antioxidant Screening: What's your Number??

"The amount of antioxidants that you maintain in your body is directly proportional to how long you will live." Dr Richard Cutler, National Institutes of Health

Your general well-being and the health of your eyes are connected. We know that consumption of certain vitamins and carotenoid antioxidants will:

- Decrease risk of **macular degeneration**
- Decrease risk of **cataracts**
- Decrease risk of **glaucoma**
- Decrease risk of **dry eye**

There is also strong evidence that abundant carotenoid antioxidants can:

- Slow the aging process
- Improve immune function
- Decrease risk of cancer
- Decrease risk of heart disease
- Decrease risk of diabetes
- Decrease risk of Alzheimer's
- Improve skin, hair, and nail health

Our state of the art Biophotonic scanner allows us to accurately monitor your carotenoid levels in your whole body – not just your eyes. The Biophotonic scanner is non-invasive, painless, fast, and inexpensive.

With this scanner we can now easily monitor your levels on a routine basis so you can work on improving your antioxidant number with proper nutrients, diet, and lifestyle. We can also tell you if the vitamins you currently take are working or not.

Since your health is important to us, we recommend all patients be scanned. ***If you do not wish to have this scan done please ask our staff for a release form to sign.***

To cover our cost you will see a \$20 fee added to your office visit.

If you want to know your number, please answer the questions on the reverse side of this page.

We believe eye care is about more than your vision. It's about you.

Antioxidant Health Assessment

Name _____

Circle any of the following health conditions that concern you or that you want to avoid:

| | | | |
|----------------------|-----------------------|--------------------|-----------------|
| Cancer | Bone & Joint Strength | Premature Aging | Stress |
| Alzheimer's/Dementia | Inflammation | Sleep Patterns | Weight Issues |
| Diabetes | Mental Sharpness | Energy Levels | Mood Swings |
| Vision Loss | Heart Disease | Periodontal Health | Immune Function |

How are you addressing your concerns? _____

Do you feel what you are doing is working? Yes No

How many servings of fresh fruit and vegetables do you eat on a daily basis? 0 1-2 3-5 6-9 10+

Do you consider yourself at your ideal weight? Yes No

How many days each week do you exercise for 30 minutes or more? 0 1 2 3 4 5 6 7

Do you smoke? Yes No

Do you take blood thinner medications? Yes No

Are you allergic to fish/shellfish? Yes No

Supplement Assessment

Do you take supplements? Yes No

If yes, how did you select your supplement? _____

What is your monthly supplement cost? _____

Are your supplements working? Yes No

How do you know? _____

Commitment to Care

How much are you willing to invest in your health each day? Less than \$2 \$2-\$3 \$4-\$5 \$5-\$8 \$8+