Health Questionnaire

Name: Date:

1. Have you ever had heart trouble or coronary disease? If so please explain:

2. Do you have a family history of heart problems or coronary disease?
If yes, please explain:

3. Do you have a history of high blood pressure (above 140/90)?

4. Do you have diabetes?
Please provide name and phone number of your doctor:

5. Do you think you are overweight?

6. Has your doctor ever said you have high cholesterol?

7. Please list any prescribed medications you are taking:

8. Please list any drug allergies:

9. Please list any over the counter medication or dietary supplements you are taking:

10. Please list any illness, hospitalization, or surgical procedure within the past 3 years:

11. Please list date of last physical examination and results:

12. Are you currently under the care of a physician?
If so, please describe and provide name and phone number of your doctor:

13. Do you have trouble sleeping? How many hours of sleep per night?

14. Do you wear eyeglasses or contacts?

15. How many cups of coffee do you drink a day? Soda?

16. How much water do you drink a day?

17. Have you ever participated in a diet and/or nutrition program?
Did you achieve your goal(s)? Was it permanent?

18. What would you like to change about your health or the way you look?

Have you ever been treated for, diagnosed as having, or currently suffering from any of the following: (*Explain below for each "Yes"*)

Skin tumors, skin cancer or melanoma? Yes No

Cancer? Yes No

Any infectious progressive illness, such as Hepatitis B, Acquired Immune Deficiency Syndrome or other conditions? Yes No

Are you currently under the care of a physical therapist? Yes No

Any circulatory disorder? Yes No

Neuromuscular/neurological disorders such as seizures? Yes No

Suffered from fainting, convulsions, recurrent headaches, dizziness? Yes No

Stroke? Yes No

Nervous or mental disorder? Yes No

Active rheumatoid arthritis? Yes No

Osteoporosis? Yes No

Anticoagulant medication? Yes No

Are you taking antidepressant medication? Yes No

Are you under hormonal treatment? Yes No

Liposuction or cosmetic surgery within the last six months? Yes No

Allergies? Yes No

Digestive problems? Yes No

Are you taking laxatives or diuretics? Yes No

Do you smoke? How many cigarettes a day? Yes No

Are you pregnant? Yes No

Please provide an explanation to anything you answered "Yes" to: