

Check all that apply to your current and past medical history and explain on the lines below:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Heart Disease or Irregularities | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Musculoskeletal Injuries/pain | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Transplants/Organ Failures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Metabolic Disorders (Diabetes, Thyroid) | <input type="checkbox"/> Other (describe below) | |
-
-

Yearly physicals? yes no | Stress tests? yes no Date of Last _____

Have you been under a physician's care for any reason during the last year? yes no

Do you take any medications? yes no

Do you have a family history of:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |

LIFESTYLE

Do you smoke? yes no | If so, how much? _____

Hours of sleep per night ____ | Do you consume alcohol? yes no | Drinks per week ____

Occupation: _____

Rate your stress level on a scale of 1 (minimum) to 10 (maximum): _____

Describe your hobbies and pastimes: _____

NUTRITION AND WEIGHT CONTROL

Present Weight: _____ Desired Weight: _____ Maximum weight: _____ Weight at 21: _____

Is weight loss easy or difficult for you? yes no | Do you diet? yes no

Describe your eating habits below (number of meals, what you eat, time of day, etc.)
