Name: Date:

Please put an **X** in each box that applies to you…

**Have you or any immediate family member ever been told you have:**

|  |  |  |
| --- | --- | --- |
|  | **Self** | **Family** |
| Cancer? |  |  |
| Diabetes? |  |  |
| High Blood Pressure? |  |  |
| Heart Disease? |  |  |
| Angina/chest pain? |  |  |
| Stroke? |  |  |
| Osteoporosis? |  |  |
| Osteoarthritis? |  |  |
| Rheumatoid Arthritis? |  |  |

**In the past 3 months have you had or do you experience:**

|  |  |
| --- | --- |
| A change in your health? |  |
| Nausea/vomiting? |  |
| Fever/chills/sweats? |  |
| Changes in appetite? |  |
| Changes in bowel or bladder function? |  |
| Shortness of breath? |  |
| Dizziness? |  |
| Unexplained weight change? |  |

**Do you have a history of:**

|  |  |
| --- | --- |
| Allergies/asthma? |  |
| Headaches? |  |
| Sexually transmitted disease? |  |
| Seizures? |  |

**Are you currently:**

|  |  |
| --- | --- |
| Pregnant? |  |
| Depressed? |  |
| Under stress? |  |

**Current Weight: \_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_**

**Date of last physical examination with your doctor: \_\_\_\_\_\_\_\_\_\_\_\_**

**Do you or have you in the past smoked tobacco?**

**YES NO**

**Do you drink alcoholic beverages?**

**YES NO**

**Have you fallen more than 2 times in the past year?**

**YES NO**

|  |
| --- |
| **Present Medications:**  (Include dosage and route of administration) |
|  |