HEALTH HISTORY

Have you ever had any of the following?:

□ Aneurysm □ Osteoporosis □ Diabetes □ Arthritis
□ Cancer □ Strokes □ Heart conditions
□ Other conditions not listed:_____

Falls and accidents- List: _____
_____
_____

Surgery and operations- List: _____
_____
_____

Do you take vitamins and/or minerals? □ Yes □ No List:_____
_____

List any medications you may be currently taking: _____
_____
_____

Do you have a family history of (please check)?

□ Cancer □ Diabetes □ Heart Conditions □ Arthritis □ Stroke
Other: _____

LIFESTYLE

Do you exercise? □ Yes □ No What/How much?_____

Do you smoke? □ Yes □ No Do you drink alcohol? □ Yes □ No

Sleep (hours per night): 4-6 6-8 8-10 12+ Is it solid sleep? □ Yes □ No

Rate your diet: Poor Fair Good Excellent

Meals per day: 1 Meal 2 Meals 3 Meals 4 Meals More than 4 meals

Signature: _____ Date: _____