General Health History

Name:

Birthdate:	Age:	Sex: □ Female □ Male

How would you rate your overall health? Mark and X at the point on the line that best describes your overall health:

Poor Fair Moderate Good Excellent

Do you have or have you had any of the following conditions? Check all that apply:

□ Heart Disease or Heart Problems
□ Heart Attack
□ Abnormal Heart Rhythm
□ Stroke
□ Diabetes
□ High Blood Pressure
□ High Cholesterol
□ Asthma
□ Abnormal Bleeding/Hemophilia
□ HIV/AIDS
□ Other _____

□ COPD/Emphysema
□ Cancer
□ Irritable Bowel Syndrome
□ Gastrointestinal Disorder
□ Fibromyalgia
□ Arthritis
□ Depression/Anxiety/Bipolar Disorder
□ Anemia
□ Epilepsy
□ Allergies

Have you had any surgeries? □ Yes □ No If yes, please list:

Procedure	Date

Please list any medications or supplements you are currently taking:

Medication Name	Dose	How Often

Are you allergic to any medications? □ Yes □ No
If yes please list and describe reaction:

Have your parents, grandparents, siblings or children (if applicable) had any of the following?

	Who?
Heart Disease/Heart Attack	□ Yes □ No
Stroke	□ Yes □ No
High Blood Pressure	□ Yes □ No
Diabetes	□ Yes □ No
Obesity/Overweight	□ Yes □ No
High Cholesterol	□ Yes □ No
Asthma	□ Yes □ No
Emphysema/COPD	□ Yes □ No
Cancer	□ Yes □ No
Arthritis	□ Yes □ No
Depression/Anxiety/Bipolar	□ Yes □ No
Dementia/Alzheimer's Disease	□ Yes □ No
Blood Disorder	□ Yes □ No
Seizures/Epilepsy	□ Yes □ No
Alcohol/Drug Abuse	□ Yes □ No
Thyroid Disease	□ Yes □ No
Osteoporosis	□ Yes □ No
Disordered Eating	□ Yes □ No
Immune Disease	□ Yes □ No

Other Medical Conditions (Please describe)

What is your current weight? _____ What is your current height? _____
Highest adult weight? _____ Lowest adult weight? _____
Have you ever tried losing weight through dieting? □ Yes □ No
If yes, please describe diets followed:

Menstrual & Pregnancy History (women only)

Age at first menses _____

Are you having regular periods?
□ Yes, my periods occur approximately every _____ days
□ No, my periods are irregular
□ No, I've had menopause
□ No, my periods have stopped for reasons other than menopause

Date of last menstrual period _____ Age at menopause (if applicable) _____
Number of pregnancies _____ Number of full term deliveries _____
Number of preterm deliveries _____ Number of living children _____

Thank you for completing this questionnaire. If you have any questions or concerns please ask.