WHOLE BODY FITNESS

LIFESTYLE WEIGHT MANAGEMENT

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 a 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"**	**Yes**	**No**
Skin tumors, skin cancer or melanoma?		
Cancer?		
Any infectious progressive illness, such as Hepatitis B, Acquired Immune Deficiency Syndrome or other conditions?		
Are you currently under the care of a physical therapist?		
Any circulatory disorder?		
Neuromuscular/neurological disorders such as seizures?		
Suffered from fainting, convulsions, recurrent headaches, dizziness?		
Stroke?		
Nervous or mental disorder?		
Active rheumatoid arthritis?		
Osteoporosis?		
Anti-coagulant medication?		
Are you taking anti-depressive medication?		
Are you under hormonal treatment?		
Liposuction or cosmetic surgery within the last six months?		
Allergies?		
Digestive problems?		
Are you taking laxatives or diuretics?		
Do you smoke? How many cigarettes a day?		
Are you pregnant?		

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

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