

TEEN PROGRAMS

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?
