Date: _____

Health History Questionnaire

Name: _____ Age: _____

Birthdate: _____/_____/_____ Weight: _____ Height: _____

Occupation: _____

Have you had any surgeries? Y N Please list surgeries and dates

_____

_____

_____

When was your most recent Lab work? _____/_____/_____
Please provide results

Lifestyle Indicators

< = less than, > = greater than

Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day	recently stopped _____(when?)
Coffee	none	<2 cups/day	>2 cups/day	recently stopped _____(when?)
Soda	none	<2 cans/day	>2 cans/day	recently stopped _____(when?)
Sweets/ refined carbs	none	<twice/day	> twice/day	recently stopped _____(when?)

Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? Y N Amount _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How would you rate your stress handling? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How often do you exercise? never rarely sometimes regularly competitively

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