Health & Lifestyle Questionnaire

A. Personal Information

1. Name:_____ 2. Date:_____

3. Address_____

_____

4. Phone Numbers (please circle preferred contact number)

a. Home:_____

b. Office:_____

c. Cell:_____

5. Confidential e-mail (to send you confidential medical information):_____

_____

6. Confidential fax (to send you confidential medical information):_____

7. Sex:_____Male _____Female 8. Height:_____

9. Weight:

a. Current Weight:_____

b. Lowest Adult Weight:_____

c. Highest Adult Weight:_____

10. Frame Size: _____Small _____Medium _____Large

11. Blood Type: _____

12. Personal Physician (and phone number):

13. Date of Birth: _____ 14. Age:_____

15. Marital Status: _____Single _____Married _____Divorced _____Widowed

16. Who lives with you in your household?

17. How many children do you have?

18. What is your current occupation?

19. How would you rate your current health?

_____Poor _____Average _____Good _____Excellent

20. What are your health related goals?

21. What are your most important expectations as a patient?

B. Medical History

Condition	Does Not Apply	Myself	Siblings	Parents	Grand Parents
1. Heart Disease					
2. Cancer					
3. Diabetes					
4. High Blood Pressure					
5. Arthritis					
Condition	Does Not Apply	Myself	Siblings	Parents	Grand Parents