

12. Do you drink alcohol? **Yes No** If yes, what is your average daily consumption?

13. Do you engage in recreational drug use? (Marijuana, Cocaine, etc.) **Yes No**

14. **If you are female please complete the following:**

- a Date of last menstrual cycle _____
- b Date of last mammogram _____
- c Do you know or suspect that you may be pregnant? _____
- d Are you breast feeding? _____
- e How many times have you been pregnant? _____
- f How many children do you have? _____
- g Bra size _____ (If having a consult for breast surgery)

15. Do you exercise regularly? If yes, what type of exercise & how often? _____

If no, can you walk up 2 flights of stairs without getting short of breath? **Yes No**

Are you trying to lose weight? **Yes No**

16. Please check the box below if you currently have or have ever had a problem with:

ABDOMEN & LIVER

- Ulcers
- Colon disease
- Gallbladder disease
- Inflammatory Bowel Disease (I.B.S.)
- Reflux or regurgitation
- Hiatal hernia
- Jaundice
- Hepatitis
- Liver problems
- Cirrhosis
- Heartburn

KIDNEY & ENDOCRINE

- Diabetes
 - Insulin dependent
 - Oral hypoglycemic agent
 - Diet controlled
- Hyperthyroidism
- Hypothyroidism
- Low blood sugar
- Kidney stones
- Kidney disease or failure
- Kidney infection
- Difficulty passing urine

NEUROLOGICAL & PSYCHOLOGICAL

- Stroke, fleeting blindness or weakness
- Seizures, convulsions, epilepsy
- Fainting
- Headaches
- Concussion or severe head injury
- Emotional problems
- Psychiatric problems or treatment
- Depression
- Anxiety

GENERAL

- Glaucoma
- Visual problems
- Tested positive for HIV or AIDS virus
- Been exposed to someone who is HIV positive
- Cancer of any kind
- Chemotherapy
- Radiation therapy

SKIN

- Scar badly
- Keloids or thick scars
- Wound healing problems or open sores
- Recent changes in any moles: color size, or appearance
- Recent changes in any skin lumps or colored areas
- Previous skin tumors or cancers

MUSCULOSKELETAL

- Leg pain
- Back pain
- Neck pain
- Arthritis
- Bone disease or tumors
- Physical limitations, appliances or prostheses
- Muscular dystrophy
- Muscular sclerosis
- Fibromyalgia

HEART

- Born with heart problems
- Heart murmur
- High blood pressure
- Low blood pressure
- Chest pains
- Heart attack
- Heart failure
- Hardening of arteries
- Congestive heart failure
- Scarlet or Rheumatic Fever
- Any heart valve disease
- Leg swelling or edema
- Leg cramping with walking
- High cholesterol
- Wolfe Parkinson White Syndrome (WPW)
- Had a stress test, if "yes" when? & results? _____
- Seen by a cardiologist, if "yes" what for? & name of the cardiologist? _____

LUNGS

- Cough or cold at present
- Bronchitis
- Shortness of breath
- Asthma
- Emphysema/COPD
- Tuberculosis
- Pulmonary embolism

BLOOD

- Low blood count or anemia
- Abnormal blood clotting
- Bruise easily or excessive bleeding
- Sickle cell trait or disease
- Varicose veins
- Deep vein thrombosis
- Blood transfusion

If you have any medical problems not on this list, please describe: _____

Signature: _____

Date: _____