

# HEALTH HISTORY

**Have you ever had any of the following?:**

- Aneurysm                       Osteoporosis                       Diabetes                       Arthritis  
 Cancer                               Strokes                               Heart conditions  
 Other conditions not listed: \_\_\_\_\_

Falls and accidents- List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgery and operations- List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take vitamins and/or minerals?  Yes     No    List: \_\_\_\_\_  
\_\_\_\_\_

List any medications you may be currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a family history of (please check)?

- Cancer     Diabetes     Heart Conditions     Arthritis     Stroke  
Other: \_\_\_\_\_

## LIFESTYLE

Do you exercise?  Yes     No    What/How much? \_\_\_\_\_

Do you smoke?  Yes     No                      Do you drink alcohol?  Yes     No

Sleep (hours per night): 4-6    6-8    8-10    12+                      Is it solid sleep?  Yes     No

Rate your diet:                      Poor                      Fair                      Good                      Excellent

Meals per day:                      1 Meal    2 Meals    3 Meals    4 Meals    More than 4 meals

Signature: \_\_\_\_\_ Date: \_\_\_\_\_