



MYFITNESSBUDDY.CO.UK

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?

Have you ever been treated for, diagnosed as having, or currently suffering from any of the following: Explain below for each "Yes"	Yes	No
Skin tumors, skin cancer or melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Any infectious progressive illness, such as Hepatitis B, Acquired Immune Deficiency Syndrome or other conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under the care of a physical therapist?	<input type="checkbox"/>	<input type="checkbox"/>
Any circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular/neurological disorders such as seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Suffered from fainting, convulsions, recurrent headaches, and dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Active rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>
Anti-coagulant medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking anti-depressive medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under hormonal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Liposuction or cosmetic surgery within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking laxatives or diuretics?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? How many cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Please provide an explanation to anything you answered "Yes" to: