

<b>Name:</b>	<b>Present Medications:</b>	<b>Height:</b>
<b>Address:</b>		<b>Weight:</b>
	<b>Date of Last Physical:</b>	<b>Weight Goal:</b>
<b>Home Phone:</b>		<b>Age:</b>
<b>Work Phone:</b>		

**Part I: Medical History**

Please circle if you have or have had any of the following and elaborate if necessary.

<b>Allergies</b>	food	environmental	
<b>Arthritis</b>	osteo	rheumatoid	
<b>Cancer</b>	type:	date diagnosed:	
	treatment:		
<b>Cardiac Problems</b>	arrhythmia	bypass surgery	
	heart attack	mitral valve prolapse	
<b>Chronic Fatigue Syndrome</b>			
<b>Chronic Insomnia</b>			
<b>Chronic Pain</b>	location:	duration:	
<b>Diabetes</b>	Type 1	Type 2	
<b>Gallbladder Disease</b>			
<b>Hair Loss</b>			
<b>Headaches/Dizziness</b>			
<b>High Cholesterol</b>	total number:	HDL:	LDL:
<b>High Triglycerides</b>	number:		
<b>Hypertension</b>	number:		
<b>Hypotension</b>	number:		
<b>Infectious/Viral Disease</b>			
<b>Intestinal Problems</b>	amoebae/parasite	chronic constipation	chronic diarrhea
	chronic nausea	colitis	crohn's
	diverticulosis/itis	irritable bowel	lactose intolerance
<b>Kidney Disease</b>			
<b>Liver Disease</b>			
<b>Lung Disease</b>	asthma	emphysema	
<b>Lyme Disease</b>	date diagnosed:	treatment:	
<b>Menstrual History</b>	irregular periods	menopausal	
	pregnancies:	number of children:	
<b>Skin Problems</b>	acne	eczema	
<b>Stroke</b>			
<b>Thyroid Disease</b>	hyperthyroidism	hypothyroidism	
<b>Ulcers</b>			
<b>Surgeries, Family Medical History And Other Significant Medical Problems:</b>			

