

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (3) if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

PERSONAL MEDICAL HISTORY

EXERCISE HISTORY

	YES	NO
1. Do you regard your work as stressful?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you regard your homelife as tense?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you a perfectionist?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you "blow up" often?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you become depressed easily?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you frequently irritable?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
1. Do you exercise at all?	<input type="checkbox"/>	<input type="checkbox"/>
2. How often? _____		
3. What type of exercise? _____		

HEALTH HABITS Check () which substances you use and describe how much you use.

Caffeine	
Tobacco	
Alcohol	
Other	

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (3) if your work exposes you to the following:

Stress	
Hazardous Substances	
Heavy Lifting	
Other	
Your occupation:	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____