

Health Review

If you feel uncomfortable answering any question, please feel free to skip to the next question. How many times per week do you exercise? What type of exercise do you do (walking, biking, treadmill, etc.)?

How many servings do you each **WEEK** of:

Please circle the best answer

Red Meat	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Chicken	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Fish	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Chips	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Ice cream	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Frozen yogurt	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Yogurt	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Cheese	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Restaurant meals	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK

How many servings do you each **DAY** of:

Milk	0	1	2	3	4	5	6	per DAY
Type of milk		Skim	1.00%	2.00%	Whole			
Fruits	0	1	2	3	4	5	6	per DAY
Vegetables	0	1	2	3	4	5	6	per DAY
Cans/glasses of soda	0	1	2	3	4	5	6	per DAY
Type of soda		Regular	Diet					
Sweets	0	1	2	3	4	5	6	per DAY

What vitamins, supplements, minerals or herbal remedies do you take? How often?

Please list your family members with significant medical problems (eg father with heart disease):

Please check-off any problems you have had in the past MONTH that you would like to discuss further (please feel free to write in more detail next to the problem or at the bottom of the page):

<input type="checkbox"/>	Fever
<input type="checkbox"/>	Excessive fatigue
<input type="checkbox"/>	Significant weight gain or weight loss
<input type="checkbox"/>	New or changing moles
<input type="checkbox"/>	Persistent rash
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Many new floaters
<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Change in your hearing
<input type="checkbox"/>	Ringing in your ears
<input type="checkbox"/>	Pain in your ears
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Nasal drainage or sinus pressure
<input type="checkbox"/>	Hoarseness or persistent throat pain
<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Cough lasting more than 10 days
<input type="checkbox"/>	Chest pain lasting more than seconds
<input type="checkbox"/>	Swelling in your legs/feet
<input type="checkbox"/>	Cramps in your legs when walking
<input type="checkbox"/>	Food or pills sticking when you swallow
<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Indigestion/heartburn

<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Rectal bleeding
<input type="checkbox"/>	Black stools
<input type="checkbox"/>	Burning with urination
<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Last menstrual period
<input type="checkbox"/>	Vaginal discharge or odor
<input type="checkbox"/>	Lump in your breast
<input type="checkbox"/>	Discharge from your nipple
<input type="checkbox"/>	Pain with intercourse
<input type="checkbox"/>	Hurt by your partner
<input type="checkbox"/>	Heavy or painful periods
<input type="checkbox"/>	Back pain
<input type="checkbox"/>	Joint pains
<input type="checkbox"/>	Recent injury
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	Trouble with your balance
<input type="checkbox"/>	Feeling blue/sad
<input type="checkbox"/>	Crying for no reason
<input type="checkbox"/>	Feeling nervous about things
<input type="checkbox"/>	Worrying about things too much
<input type="checkbox"/>	Irritable, snap at other people
<input type="checkbox"/>	Trouble sleeping
<input type="checkbox"/>	Tremor or shaking
<input type="checkbox"/>	Hot or cold when others are not