**GENERAL HEALTH QUESTIONNAIRE**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:** Do you suffer or have you suffered from any of the following: *please tick*

* Chronic Pain
* Migraines / headaches
* Osteoporosis / fractures
* Stroke / Seizures
* Liver / Kidney disease
* Cancer / type:
* Any surgical operations
* Any major accidents / injuries
* High Blood Pressure
* Heart disease, Angina, Heart Attack
* Heart Bypass Surgery
* Diabetes Mellitus
* Asthma/ Chronic Lung disease
* Anxiety / Depression
* Other Mental health illness
* Osteoarthritis
* Any Other condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Is there a family history of any of the above listed illnesses, please record them here:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** List current Medications including supplements such as vitamins etc.
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**ALLERGIES**: Are you allergic to or have you had any significant side effects from any medications ?
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**SMOKING:** Do you currently smoke; *Please circle*  YES / NO OR have you ever smoked? YES / NO

**VAPING:**  Do you currently vape; please circle YES/NO OR have you ever vaped? YES/NO

How many Cigarettes/Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year commenced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**ALCOHOL:** Do you drink alcohol? *Please circle* YES / NO

How many standard drinks per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days per week do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_
**EXERCISE:** do you exercise regularly?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What type of exercise do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Weight**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Waist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_