Medical History

Personal Physician: _____ Telephone: _____

Date of last physical: _____

Are you allergic to medicines? Which ones? _____

Are you allergic to foods? Which ones? _____

Are you allergic to the environment? What? _____

Please list any regular medications, prescriptions or over the counter, that you take: _____

Please list any regular vitamin, mineral, or herbal supplements you take: _____

Please list any major operations you have had, and the year: _____

Please list any major injuries or accidents that you have had, and the year: _____

Please list any major illnesses or hospitalizations you have had, and the year: _____

Write the approximate year that you have incurred any of the following conditions:

____ anemia	____ drug reaction	____ hypoglycemia	____ parasites
____ arthritis	____ eczema	____ jaundice	____ pneumonia
____ asthma	____ emphysema	____ kidney infection	____ psoriasis
____ bladder infection	____ epilepsy	____ kidney stones	____ rheumatic fever
____ blood transfusion	____ gallstones	____ LB pressure	____ skin boils
____ bronchitis	____ heart attack	____ measles, German	____ syphilis
____ cancer	____ heart disease	____ measles, regular	____ tuberculosis
____ chicken pox	____ hepatitis	____ mental problems	____ ulcer
____ colitis	____ HB pressure	____ migraines	____ whooping cough
____ diabetes	____ HIV/AIDS	____ mumps	
____ diphtheria	____ hives	____ obesity	

Any other medical diagnosis you have from past or present: _____

Exercise Information

How often you exercise weekly? _____

What form of exercise? _____

How long do you exercise? _____