HEALTH QUESTIONNAIRE

NAME				DATE	DATE		
			S QUESTIONNAIRE THOROUGHLY WER. ANSWER ALL THE QUESTION)FF THE		
1.	YES	NO	ARE YOU HARD OF HEARING?				
2.	YES	NO	HAS YOUR DOCTOR EVER SAID YOUR BLOOD PRESSURE WAS TOO HIGH OR TOO LOW? PLEASE SPECIFY/				
3.	YES	NO	ARE YOUR ANKLES OR FEET OFTE	N SWOLLEN?			
4.	YES	NO	DO YOU EVER HAVE SPELLS OF DIZZINESS?				
5.	YES	NO	HAVE YOU EVER HAD A SERIOUS INJURY?				
6.	YES	NO	HAVE YOU HAD SURGERY RELATED TO YOUR CURRENT PROBLEM?				
			If yes, please describe				
7.	YES	NO	DO YOU CURRENTLY SMOKE? If y	s, how much?			
8.	YES	NO	ARE YOU ON A SPECIAL DIET? Please specify				
9.	YES	NO	ARE YOU PREGNANT? (Women only				
10.	YES	NO	HAVE YOU FALLEN IN THE LAST 3	MONTHS?			
11.	YES	NO	DO YOU CURRENTLY HAVE ANY V	OUNDS THAT WON'T HEAL?			
12.	DO Y	OU OR	ANY MEMBER OF YOUR IMMEDIA	ΓΕ FAMILY HAVE A HISTORY	OF:		
				SELF FAMILY			
	A.		ROINTESTINAL PROBLEMS				
	C.		HEART CONDITION () ()				
			PACEMAKER				
	E.		L/BLADDER DYSFUNCTION	` ' ' '			
	F.		PLAINED WEIGHT LOSS OR GAIN				
	G.	SHORTNESS OF BREATH() ()					
	H.	SEIZURE DISORDER/EPILEPSY () ()					
	I.	SEVERE HEADACHES() ()					
	J.	HYPOGLYCEMIA() ()					
	K.	DIABETES () () ASTHMA OR RESPIRATORY PROBLEMS () ()					
	L. M.		TE	. , . , ,			
	N.		ER	` , ` ,			
	O.		PPOROSIS	· / / /			
	P.		CCULOSIS, or HEPATITIS.	` , ` ,			