Please list all of the following if applicable:

Accidents: ____ Date(s): ____________________

Injuries (fractures/sprains/etc): _______________________________ Date(s): ____________________

Surgeries: ____Date(s): ____________________

Date of Last:

Physical: __________ Blood Work: ________ Urine Analysis: _________ X-rays: ________ MRI: ________

Other Procedure: ____

Health Habits: How much per day?

Caffeine (coffee, tea, soda): ______ Alcohol: ______ Tobacco: ______ Hours of sleep: _______

Water: ________ Exercise (type and amount): __________________________________

Any special diet? ___________________

Medications (Prescription and Over the Counter)/Supplements

1. _____________________________________ Reason: ____________________________________

2. ______________________________________ Reason: ____________________________________

3. ______________________________________ Reason: ____________________________________

4. ______________________________________ Reason: ____________________________________

5. ______________________________________ Reason: ____________________________________

Height: ______________ Weight: _____________ Any allergies? __________________________________

Recent weight gain? Y N

Recent weight loss? Y N

Do you have a pacemaker? Y N Atrial Fibrillation? Y N Women: could you be pregnant? Y N