MEDICAL HISTORY (PLEASE TICK)

- ☐ ARTHRITIS / ORTHOPAEDIC PROBLEMS
- ☐ ALLERGIES / HAY FEVER
- ☐ ASTHMA
- ☐ ALCOHOLISM
- ☐ ALZHEIMER'S DISEASE
- ☐ AUTOIMMUNE DISEASE
- ☐ BLOOD PRESSURE
- ☐ BRONCHITIS
- ☐ CANCER
- ☐ CHRONIC FATIGUE SYNDROME
- ☐ CARPEL TUNNEL
- ☐ CHOLESTEROL
- ☐ CIRCULATORY PROBLEMS
- ☐ COLITIS
- ☐ DENTAL PROBLEMS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULAR DISEASE
- ☐ DRUG ADDICTION
- ☐ EATING DISORDER
- ☐ EPILEPSY
- ☐ EMPHYSEMA
- ☐ EYES, EARS, NOSE & THROAT PROBLEMS
- ☐ FIBROMYALGIA
- ☐ FOOD INTOLERANCE
- ☐ GASTROESOPHAGAEL
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEADACHES / MIGRAINES
- ☐ HEART DISEASE
- ☐ INFECTION / CHRONIC
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY OR BLADDER DISEASE
- ☐ LEARNING DISABILITIES
- ☐ LIVER / GALLBLADDER DISEASE (STONES)
- ☐ MENTAL ILLNESS
- ☐ NEUROLOGICAL PROBLEMS
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ OBESITY
- ☐ OSTEOPOROSIS
- ☐ PNEUMONIA
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SEASONAL AFFECTIVE DISORDER
- ☐ SKIN DISORDERS
- ☐ TUBERCULOSIS
- ☐ ULCER
- ☐ URINARY TRACT INFECTION
- ☐ VARICOSE VEINS
- ☐ DIZZINESS
- ☐ TINNITUS
- ☐ SKIN PROBLEMS
- ☐ PROSTATE
- ☐ MENSTRUAL IRREGULARITIES
- ☐ PMS
- ☐ ENDOMETRIOSIS
- ☐ BREAST CANCER
- ☐ SURGICAL MENOPAUSE
- ☐ PREGNANT (TRYING TO CONCEIVE)
- ☐ OTHER - PLEASE SPECIFY

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HEALTH HABITS

- ☐ SMOKE - NO PER DAY _____
- ☐ ALCOHOL - UNITS PER DAY _____

EXERCISE

- ☐ 1 -3 TIMES PER WEEK
- ☐ 3 TIMES OR MORE PER WEEK
- ☐ AEROBIC / GYM
- ☐ RUN / JOGGING
- ☐ OTHER - PLEASE SPECIFY

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