www.GlobalNutrition.life
One Lockwood Drive, Suite 200 Pittsford, NY 14534
ClientSupport@GlobalNutrition.life 585.310-7860

Health Questionnaire

Referred By : _____

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____ Date: _____

Phone (home/cell): _____ (w): _____ Gender: _____

Are you: Married Single Separated Divorced (Circle One)

Highest year completed in school: _____Birth Date: _____

Age: _____ Height: _____ Weight: _____ Cholesterol: _____

Blood Pressure: _____ Physician Contact Info. : _____

What are the top 3 goals you would like to accomplish with your Global Nutrition Plan?

1. _____

_____

2. _____

_____

3. _____

_____

How is your dental health? _____

How often do you have bowel movements? _____ Per day/week/month Urinate? _____ per day

Are your nails weak or brittle? _____

Do you have pets? Type? _____

Please list prescriptions and over-the-counter medications you currently take: _____

_____

_____

_____

How often do you use recreational drugs? Type? _____

_____

How often do you drink alcohol?

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Please check off any of the following that pertain to you (recent past or present):

- ❑ Acne/ blemishes
- ❑ Addiction (drugs, alcohol)
- ❑ Anemia
- ❑ Anorexia
- ❑ Anxiety or nervousness
- ❑ Arthritis (Rheumatoid or Osteo)
- ❑ Bladder Infections (Cystitis)
- ❑ Bloating, gas, or indigestion
- ❑ Blood sugar problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Colds or flu
- ❑ Cold sores
- ❑ Chronic fatigue
- ❑ Constipation
- ❑ Dandruff
- ❑ Depression
- ❑ Diabetes I (insulin dependent)
- ❑ Diabetes II (Adult Onset)
- ❑ Diarrhea
- ❑ Difficulty *losing* weight
- ❑ Difficulty *gaining* weight
- ❑ Emotional problems (instability or sensitivity)
- ❑ Emphysema
- ❑ Fainting
- ❑ Gall Bladder Problems
- ❑ Gout
- ❑ Hair Loss or poor hair growth
- ❑ Headaches
- ❑ Heart disease or problems
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Herpes type I mouth/face
- ❑ Herpes type II genital
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV
- ❑ Hot flashes
- ❑ Hypoglycemia
- ❑ Insomnia
- ❑ Intestinal problems
- ❑ Kidney Stones
- ❑ Liver problems
- ❑ Loose stools
- ❑ Memory loss or confusion
- ❑ Menopausal symptoms
- ❑ Nails, poor growth
- ❑ Nails, white spots
- ❑ Panic attacks
- ❑ Parasites
- ❑ Pregnant or nursing mother
- ❑ Respiratory problems
- ❑ Ringing in ears
- ❑ Seizures
- ❑ Severe mood swings
- ❑ Skin conditions
- ❑ Stroke
- ❑ Suicidal tendencies
- ❑ Thyroid Condition
- ❑ Ulcer
- ❑ Yeast Infections
- ❑ Other
- ❑

Describe your daily energy levels: _____

Describe your daily stress levels : _____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease). _____

_____

_____

_____

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Directions: Circle Y for Yes or N for No. Answer all questions. Guess if not sure.

For Men Only

Do you have trouble getting or maintaining an erection?	Y N
Have you ever had a prostate problem?	Y N

For Women Only

Have you ever had an abnormal PAP smear?	Y N
Have you ever had a discharge from the breast?	Y N
Have you ever had a mammogram (breast x-ray)?	Y N
Do you use birth control pills?	Y N
Have you ever had any complications of pregnancy?	Y N
Have your periods usually been painful?	Y N
Have you suffered from PMS?	Y N
Have you been troubled by persistent vaginal discharge or irritation?	Y N
Have you had severe hot flashes or sweats?	Y N

Do you have any known allergies to food or medications?

_____

History of surgeries/hospitalization:

1.

2.

3.

Vaccinations you have received over your lifetime (circle all that apply):

Measles, mumps, Rubella, smallpox, Influenza, tetanus, Diphtheria, Hepatitis B, Varicella

HPV or other_____

List any special interest or passions:

1.

2.

3.