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 ____________________________

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 ____________________________