

Medical and Lifestyle Information:

Patient ID Number _____
 (subjects ~initials)
 Date of Birth: _____
 Male/Female _____
 Today's Date: _____
 Reviewer's Initials _____

Initial Visit:				
Final Visit:	Date	Height (cm)	Weight (kg)	Blood Pressure (mmHg)

Do you have the following medical conditions (circle Yes or No)?\

- | | | |
|--|--------|--------|
| 1. Heart disease | Yes | No |
| 2. Diabetes | Yes | No |
| If you answered "Yes" to Question 2, please circle one of the following: | Type 1 | Type 2 |
| 3. High blood pressure (hypertension) | Yes | No |
| 4. Renal or kidney disease/failure | Yes | No |
| 5. Gastrointestinal condition such as Crohn's disease, irritable bowel syndrome, ulcer,
or history of bowel surgery | Yes | No |
| 6. History of blood clotting disorder | Yes | No |
| 7. Liver disease such as cirrhosis | Yes | No |
| 8. Condition that requires the use of steroid medication | Yes | No |
| 9. Thyroid disease or thyroid problem requiring treatment | Yes | No |
| 10. Do you take any type of doctor-prescribed medication? | Yes | No |

If you answered YES, please provide details of the medication in the chart below

Date Started	Name of Product (type of product)	Reason for Use

- | | | |
|--|-----|----|
| 11. Do you currently smoke? | Yes | No |
| 12. Do you exercise more than ten (10) hours a week or play sports regularly? | Yes | No |
| 13. Are you currently on a weight-loss program or diet? | Yes | No |
| 14. At the Final Visit please provide feedback about this Program: (Complete Feedback on other side) | | |

Return this form at the conclusion of the program.