BioMeridian Health Questionnaire

Name: ______________________ Date: ______________________

1. Please list all health issues or symptoms you have in order of importance.

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

2. Please list all prescription medications you are currently taking.

Name of Medication	Reason for Medication

3. List all Vitamins & Supplements you are currently taking.

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

4. Please list all surgeries you have had and the year they were performed.

	YR		YR
	YR		YR
	YR		YR
	YR		YR
	YR		YR

5. Family History

	Age	Health Issues &/or cause of death
Mother		
Father		
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		
Brothers		
Sisters		
Children		

6. Do you have a pacemaker or implanted device? ___________

7. If female, are you pregnant? _________

8. Social History (check all that apply)

( ) Smoking How many packs/day?
( ) Other Tobacco Use
( ) Alcohol Use How many glasses/day?
( ) Drug Use
( ) Drink coffee/tea How many cups/day?
( ) Diet is: Balanced / Not Balanced
How many meals/day?
( ) Rest is: Sufficient / Not Sufficient
How many hours per night?
( ) Recreation is: Sufficient / Not Sufficient
How many days/wk?
How long is your workout?
( ) My Family Stress is: Severe / Moderate / Minimal / None
( ) How do you like work: I love it / It's OK / I hate it
( ) My Job Stress is: Severe / Moderate / Minimal / None