

Hirani Wellness Medical Center, Inc.

Karima Hirani MD, MPH

MEDICAL AND HEALTH HISTORY QUESTIONNAIRE ADULT

- Please complete this form prior to your visit. Bring it with you the day of your visit. Please do not mail it!
- This questionnaire is an important part of your visit. Accurate completion of this form will assure that you receive the best possible care in the time set aside for your visit.
- Please allow up to 90 minutes to complete this form. Please do not wait until the night before your visit.

PERSONAL INFORMATION

Name		Age	Sex	Marital Status	
Address		City		State	Zip
Home Phone	Mobile	Office		E-mail	
Birthdate		Occupation		Past Occupation	
Height	Current weight	Lowest adult weight		Highest	Desired
Name of spouse or partner		Age	Spouse's Occupation		
Children: Names, ages, gender					
Name and address of present physician					
Who should we contact in case of emergency			Phone	Relationship	
Who may we thank for referring you			Travel time to office		

FINANCIAL AGREEMENT AND CONSENT

<p>I claim full financial responsibility for all services rendered at Hirani Wellness. I understand that payment is required in full at the time of service. I certify the information provided in this questionnaire is correct to the best of my knowledge. I agree to notify Hirani Wellness of any changes with respect to the information provided in this questionnaire. I consent to medical evaluation and treatment by Dr. Hirani and the staff of Hirani Wellness. I have received a copy of Privacy Practices and consent to use and collection of personal and medical information described therein. I give permission to be contacted at the above numbers (including voice mail) for scheduling and office-patient communication.</p>		
Signed X	Date:	Relationship to patient:

INSURANCE INFORMATION

Insurance company	
Address	
Phone	Group or policy number
Insured's name	
<p>I hereby authorize the release of any medical information necessary in the processing of my claim. I also request payment to myself or to the party who provided care.</p>	
Signed X	Date: Relationship to patient:

Name: _____

PLEASE DESCRIBE YOUR MAJOR PROBLEMS OR SYMPTOMS. If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided; if you need more space, add a separate sheet of paper.

HAVE YOU SEEN OTHER PHYSICIANS FOR THESE PROBLEMS? Indicate the results of their evaluations:

PLEASE BRING RECENT MEDICAL RECORDS, IF POSSIBLE, ESPECIALLY LAB TESTS OR HOSPITAL DISCHARGE SUMMARIES.

WHAT HABITS, ACTIVITIES, OR ATTITUDES DO YOU CONSIDER TO HAVE CONTRIBUTED TO ANY OF YOUR PROBLEMS?

LIST HOUSEHOLD MEMBERS NOW LIVING WITH YOU? INCLUDE FAMILY MEMBERS, NON-FAMILY AND PETS

NAME	RELATIONSHIP	AGE	OCCUPATION

Please be specific with your answers regarding types and quantities where requested

SMOKING

Do you smoke?	How much per day?	For how long have you smoked?	
Did you ever smoke?	How much?	For how long?	When did you stop?
Do you live or work closely with a smoker?			

ALCOHOL

Specify what type of alcohol, amount and frequency		
Do you drink to excess?	Did you ever drink to excess?	When did you stop?

Name: _____

RECREATIONAL DRUGS

Specify type and frequency (you may discuss privately with Dr. Hirani)

CAFFEINE

How much of each of the following do you consume: Regular coffee?		Tea?
Chocolate or cocoa?	Colas?	Other caffeine soft drinks?

COSMETICS

Do you use cosmetics?	Perfumes?	Aftershaves?	Scented soaps?
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NON-PRESCRIBED MEDICATIONS

List any laxatives, aspirin, antihistamines, decongestants, stimulants, etc.

PRESCRIBED MEDICATIONS

Name of drug and dose

ALLERGIES TO MEDICATIONS

Name of drug and type of reaction

OTHER ALLERGIES AND SENSITIVITIES

Foods, Pollens, Animals, Chemicals, etc.

EXERCISE

Do you exercise regularly?	Type(s) of exercise?	
How often?	Length of session?	Do you sweat?

STRESS REDUCTION

Do you do any stress reduction or relaxation such as meditation, yoga, prayer, self-hypnosis, etc.?

How often? _____ Length of session? _____

STRESS

What level of stress do you consider yourself to be under? Low Medium High

SLEEP

How many hours per night?	Restless or restful?	What time do you retire?
Do you wake during the night?	Do you dream?	

HOBBIES AND INTERESTS

What are your hobbies or other life interests?

PAST HISTORY

Did your mother have any problems during pregnancy with you? (Stress, illness, smoking, medications, alcohol)

Bottle fed Breast fed

HOME LIFE AS A CHILD

<input type="checkbox"/> Loving	<input type="checkbox"/> Abusive	<input type="checkbox"/> Argumentative	<input type="checkbox"/> Friendly
<input type="checkbox"/> Supportive	<input type="checkbox"/> Peaceful	<input type="checkbox"/> Educational	<input type="checkbox"/> Single-parent
<input type="checkbox"/> Stressful	<input type="checkbox"/> Loud	<input type="checkbox"/> Alcoholic	<input type="checkbox"/> Lonely

Other comments:

CHILDHOOD ILLNESSES

<input type="checkbox"/> Colic	<input type="checkbox"/> Allergies	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> German measles
<input type="checkbox"/> Eczema	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Recurrent colds	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Polio	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Thrush	<input type="checkbox"/> Persistent diaper rashes
<input type="checkbox"/> Learning disability	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Other comments:

PAST HISTORY

Other past medical problems as a child or adult. Please give dates and specifics. See also pages 5 and 6.

ANTIBIOTICS

Have you ever been on frequent or prolonged antibiotic therapy such as Erythromycin, Penicillin, Tetracycline, Sulfa drugs, Flagyl, etc.?

TRAVEL

Have you ever traveled out of the country?	Had traveler's diarrhea?
Been treated for parasites?	Been tested for intestinal parasites?

HOSPITALIZATIONS

List major hospitalizations. Please give dates, locations, diagnoses, lengths of hospital stays, and surgeries.

SYMPTOM AND SYSTEM REVIEWCheck **C** for **current** problem;Check **I** for **intermittent** problem;Check **P** for **past** problem

C	I	P	SYMPTOM	Reserved for Dr. Hirani Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck lumps or swelling	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts or fainting	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain or itching	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watering eyes or redness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earaches or drainage	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noises or ringing in ears	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent ear infections	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems or decay	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore or bleeding gums	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coated tongue	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste or smell	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores in or around mouth	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores or fever blisters	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus or nasal congestion	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent fevers or chills	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarse voice	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing or gasping	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest colds or pneumonia	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heartbeats	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Racing heart	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet or ankles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing at night	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins or phlebitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring indigestion	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal gas or flatulence	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or cramps	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or loose stools	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal itching	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood with stools	
	/ day		Number of bowel movements	
			Color of bowel movements	

Name: _____

Check **C** for **current** problem;

Check **I** for **intermittent** problem;

Check **P** for **past** problem

C	I	P	SYMPTOM	Reserved for Dr. Hirani Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in rectum	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or pancreatitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis or diverticulosis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brown or red urine	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased force of urine	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continual urge to urinate	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involuntary escape of urine	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urination	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder infection	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aching muscles or joints	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful feet	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trembling or tremors	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin tumors	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff or seborrhea	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching or burning skin	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid (low)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid (high)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel excessively warm	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel excessively cold	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constant hunger	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue or weariness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness or anxiety	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sought psychological help	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MEN ONLY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful testicles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	

MEDICAL HISTORY

Please indicate if you or any of your family members including grandparents have ever had any of the following problems. Specify who, including yourself .	
Alcoholism	High cholesterol
Allergies	Frequent infections
Anemia	Urinary infections
Arthritis	Lupus
Asthma	Mental illness
Bleeding or bruising	Migraines
Cancer	Pneumonia
Convulsions or epilepsy	Polio
Crohn's disease or colitis	Prostate problems
Diabetes	Rheumatic fever
Digestive disease	Rheumatoid disease
Herpes or shingles	Sinus disease
Hypoglycemia	Strokes
Drug problems	Thyroid problems
Eczema or psoriasis	Tuberculosis
Heart disease	Ulcers
Hepatitis	Venereal disease
High blood pressure	Weight problems
Comments:	

PREVIOUS TESTS - Specify when, if known:

Last Physical Exam	EKG
X-rays	Stress EKG
GI series	Angiogram – catheterization
Gall bladder tests	Ultrasound tests
Kidney - bladder series	Blood tests
Bone mineral density (DEXASCAN)	Mammogram
Other Tests or Comments:	

IMMUNIZATIONS - Specify when, if known:

Smallpox	Tetanus
Polio	Flu
Mumps	Measles
Pneumonia	Diphtheria
Pertussis	
Comments:	

LIVING ENVIRONMENT

Living environment: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Country <input type="checkbox"/> Seaside <input type="checkbox"/> Lakeside		
Type of heat: <input type="checkbox"/> Gas <input type="checkbox"/> Electric	Humidifier?	Wood Stove?
Type of insulation:	The cellar is: <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Musty <input type="checkbox"/> Dusty <input type="checkbox"/> No cellar	
Is the house old or new?	Has it been treated for pests?	What kind?
Do you use feather or down covers, comforters or jackets?		Do you have an air filter or cleaner?
Are there animals at home or places you visit frequently?		What kind?
Do you use strong chemical cleaners, solvents, paints, etc?		What kind?

Name: _____

GYNECOLOGICAL HISTORY FORM

Date last period began?		Date of last pelvic exams?	
Date prior period began?		Age at first period?	
Date of last pap smear?		Were the results normal?	
Have you ever had an abnormal pap?		When?	
Results?		Treatment?	
Are you sexually active?	Do you have intercourse?	Do you practice safe sex?	
Are you trying to get pregnant?		How long?	
Current birth control method?		How long?	
Problems with it?			
Past birth control methods?			
Normally (not on pills) the number of days from the start of one period to the start of the next?			
Number of days of flow?	Amount of bleeding?	Amount of cramps?	
Premenstrual symptoms?			
Starting when?			
Any changes in your normal pattern?			
Any bleeding between periods?		When?	
Any unusual pelvic pain, pressure, or fullness?		When? Describe?	
Any unusual vaginal discharge or itching?		Describe?	
How long?		Past treatment?	
Any sexual concerns to discuss?			
Any past history of tubal infection?			
Any past history of sexually transmitted disease?			
Any history of DES exposure?			
Have you ever had herpes?		Venereal warts or papilloma virus?	
Do you pass clots?		Type of pad or tampon used?	
Number of pregnancies?	Dates of pregnancies?		
Outcome of the pregnancies?			
Describe any infertility problems?			
Have you ever breastfed?			
Have you ever had breast lumps?			
Do you ever have nipple discharge? (describe)			
Other?			

Check **P** for **premenstrual**; Check **D** for **during** the menstrual period; Check **A** for **after** menstrual period

P	D	A	SYMPTOM	P	D	A	SYMPTOM
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constant cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar cravings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:
How severe are the symptoms?							
What treatments have you tried?							

DIET SURVEY

Please take the time to answer these questions specifically and concisely.

Specify what foods and beverages you normally consume during a typical day (Please be specific):		
	Weekdays	Weekends
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Name: _____

What do you normally eat or drink between meals?	
Do you binge?	Do you use foods for reward or escape?
If so, what foods or beverages do you use, and how often?	
What foods would be most difficult for you to give up?	
Do you have specific food cravings?	What foods?
What work or scheduling considerations might create difficulties for you in trying to change your eating and other health habits?	
List any known food sensitivities	
Number of glasses or water per day	

	Frequent	Often	Occasional	Seldom	Never
Alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat at restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat at fast food restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pastries, cookies, candies, ice cream, sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add sugar to coffee, tea, cereals, other foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colas or other soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instant breakfasts, pop tarts, doughnuts, muffins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold breakfast cereals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine drinks (coffee, tea, cola, chocolate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep fried foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Margarine of any type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain hot cereals (oatmeal, wheatena, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat (beef, veal, pork, ham, lamb, liver)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken or turkey (<input type="checkbox"/> regular <input type="checkbox"/> free range)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processed meat (bologna, turkey roll, sausage, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh raw fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grains or whole grain breads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White bread or white flour products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beans and legumes (lentil, kidney, chickpea, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yogurt (<input type="checkbox"/> whole <input type="checkbox"/> lowfat <input type="checkbox"/> plain <input type="checkbox"/> flavored)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk (<input type="checkbox"/> whole <input type="checkbox"/> lowfat <input type="checkbox"/> skim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs (<input type="checkbox"/> regular <input type="checkbox"/> free range)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbs, fresh and dried, or spices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink adequate water (<input type="checkbox"/> tap <input type="checkbox"/> filtered <input type="checkbox"/> bottled)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat if excessively bored or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallow food before chewing well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hurried or rushed meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stuff yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read and understand food labels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneak or hide foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate fiber or roughage in diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial sweeteners (saccharin, Nutrasweet, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shop at health food stores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

