

Health Appraisal Questionnaire Introduction

Name: _____ Date: _____

Nutritional supplements currently taking:

Type and brand	Amount per day	Type and brand	Amount per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications(including oral contraceptives and non prescription, i.e. Advil, Tylenol, Tagamet, Aspirin, Tums, etc.) List type and amount per day, week, or month: _____

Typical daily diet:

Breakfast _____
 Snack _____
 Lunch _____
 Snack _____
 Dinner _____
 Snack _____

Cups/day: Coffee _____ Tea/Iced tea _____ Soda _____ Milk _____ Water _____ Other? _____
 Alcoholic drinks/week _____ Cigarettes/day _____