



Health Appraisal 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, Aspirin, Tums, etc.) List type and amount per day, week, or month: _____

Typical Daily Diet:

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

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