The Focus

Hormone Assisted Diet Questionnaire

NAME: AGE: DATE:

DATE OF BIRTH: HEIGHT:

ALLERGIES:

All Prescription Medications:

All Supplements:

Medical History:

Asthma	Yes	No
Diabetes	Yes	No
Hypoglycemia	Yes	No
Neuro/Epilepsy	Yes	No
Hepatitis	Yes	No
Depression	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Blood Transfusion	Yes	No
Heart Disease	Yes	No
Thyroid	Yes	No
Rheumatic Fever	Yes	No
Blood Abnormality	Yes	No

History of Plastic Surgery Yes No