GIANTS Care Men's Health Questionnaire

Name:	
Address:	
Email:	
Mobile:	
DOB:	

Do you have any medical conditions? (eg, High Blood Pressure, Type 2 Diabetes, High Cholesterol, Sleep Apnoea, etc)

_____
_____

Do you take any medications?

_____
_____

Do you have a family history of High Blood Pressure, Type 2 Diabetes, High Cholesterol?

_____
_____
_____

Do you have any injuries?

_____
_____

Do you smoke? If so, how many per day?

_____

Do you drink alcohol? If so, how many days per week and how many drinks each of those days?

_____
_____

What is your current weight? _____
What is your goal weight?_____
What's the heaviest you have been? How long ago?

_____
_____

Do you eat fresh foods? (eg, Fruit, salads, vegetables etc)

_____
_____

Are you vegetarian?_____
Why do you want to participate in the GWS Giants Men's Health Program?

_____
_____
_____