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## HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

- 1.) How many servings of fresh, raw fruit do you have daily? \_\_\_\_\_
- 2.) How many servings of fresh, raw, or cooked vegetables do you have daily? \_\_\_\_\_
- 3.) Do you exercise on a regular basis? \_\_\_\_\_ If yes, what kind, how often and how long?  
\_\_\_\_\_
- 4.) How much water do you drink daily? \_\_\_\_\_
- 5.) How much caffeine do you have daily? \_\_\_\_\_
- 6.) Are you concerned about your weight? \_\_\_\_\_
- 7.) Are you concerned about a family history of health problems? \_\_\_\_\_ If yes, what illnesses have your family members had? \_\_\_\_\_  
\_\_\_\_\_
- 8.) Are you concerned about your cholesterol? \_\_\_\_\_ When was the last time you had your Cholesterol checked? \_\_\_\_\_
- 9.) Do you smoke? \_\_\_\_\_ If yes, how much on a daily basis? \_\_\_\_\_
- 10.) Do you ever tan in a tanning bed? \_\_\_\_\_ If yes, how often? \_\_\_\_\_
- 11.) Do you use sunscreen? \_\_\_\_\_ If yes, do you use in on a regular basis? \_\_\_\_\_
- 12.) What type of sunscreen do you use? \_\_\_\_\_
- 13.) What medications are you presently taking? \_\_\_\_\_  
\_\_\_\_\_
- 14.) If you take any nutritional or herbal supplements, what do you take and how regularly do you take them? \_\_\_\_\_
- 15.) When was the last time you had a tetanus booster? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_