Diets:

Have you ever used any diet pills or shakes?

If yes, what were the results?_____
_____

Hypertension:

Have you ever been diagnosed with high blood pressure?	Y	N
Have you ever been prescribed medication to control high blood pressure?	Y	N

If yes, explain_____

Smoking:

Do you smoke?	Y	N
If no, did you ever smoke? How long ago? _____	Y	N

If yes, how much do/did you smoke? _____

If you do smoke, do you want to quit?	Y	N

Heart:

Have you ever been diagnosed with a heart problem?	Y	N
Do you ever suffer from heart pain?	Y	N
Do you ever feel faint or have spells of dizziness?	Y	N