



**Date:**

**Personal Information**

Name

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Age

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Height (cms):

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Weight (kgs):

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Home Address

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Tel No

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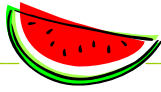
E-mail Address:

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**Medical History**

Diabetes	Yes / No "Yes" if on treatment with diet/ medicines/ Insulin
High blood pressure	Yes / No Systolic BP > 140 mm Hg / Diastolic BP > 90 mm Hg on medicines
High cholesterol / triglyceride / Uric acid levels	Yes / No Give the values
Hypothyroidism	Yes / No
Current medications	Yes / No



**Lifestyle Factors**

Smoking	Ex-smoker / current smoker / never smoked
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If current smoker,	Number of cigarettes smoked / day
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Substance Abuse :	Tobacco / others : Yes / No, If yes, daily / occasionally
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Alcohol consumption	Yes / No.
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If yes,	How many times in a week?
<hr/>	
	How many drinks?
<hr/>	
	What do you munch with the drinks?
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Occupation	Sedentary / physically active job
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**Family History**

Heart attack / stroke / sudden death

Father / Mother / Siblings

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Diabetes Mellitus

Father / Mother / Siblings

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High blood pressure

Father / Mother / Siblings

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Obesity

Father / Mother / Siblings

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High cholesterol / lipid levels

Father / Mother / Siblings

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Ice creams	
Fruits	
Fruit juices	
Indian sweets	
Fried foods	
Salads	

USE OF	HIGH	AVERAGE	LOW
Oil			
Ghee			
Butter			
Coconut			
Groundnut			
How much oil are you using in a month?			
Number of family members:			
Type of oil			

**Exercise**

Do you exercise:

Yes / No



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How many times in a week?

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Do you walk / jog / use a treadmill / cycle / swim / workout in the gym or describe any other activity.

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How long is your session?

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