



Registration ID:.....

Health Care Option:.....

PERSONAL HISTORY

DATE:.....

NAME:.....

AGE:..... DATE OF BIRTH:..... GENDER: MALE/FEMALE

ADDRESS:.....

.....

TEL:..... MOBILE:.....

E-MAIL:.....

OCCUPATION:.....

REF DOCTOR:.....

CLINICAL HISTORY

CLINICAL CONDITIONS	YES/NO	SINCE
DIABETES		
HEART DISEASE		
KIDNEY DISEASE		
THYROID		
ASTHAMA		
WATER RETENTION		
ULCERS		
SURGERY		
ALLERGIES		
OTHERS		

MEDICINES

MEDICINE	DOSE	FREQUENCY

PHYSICAL MEASUREMENTS

HEIGHT:.....cms WEIGHT:.....kgs BMI:.....

WAIST:..... HIP:..... WHR:.....

BLOOD PRESSURE:..... FAT %:..... LBM:.....TBW:.....

VISCERAL FAT:..... METABOLIC AGE:..... BLOOD PRESSURE:...../.....

EXERCISE ROUTINE:.....