

## Long-Term Basic Questionnaire

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<b>*Full Name:</b>			<b>*Spouse Name:</b>		
<b>Date of Birth:</b>			<b>Date of Birth:</b>		
<b>Address:</b>					
<b>*Home Phone:</b>			<b>E-Mail:</b>		
<b>Work Phone:</b>			<b>Work Phone:</b>		
<b>Last Physical:</b>		<b>Clinic Name:</b>	<b>Last Physical</b>		<b>Clinic Name</b>
<b>Height:</b>		<b>Weight:</b>	<b>Height</b>		<b>Weight</b>
<b>Tobacco User:</b>		<b>How long?</b>	<b>Tobacco User:</b>		<b>How long?</b>
<b>Medications</b>		<b>Dosage</b>	<b>Reason</b>	<b>Medications</b>	
<b>Surgeries or Hospital Stays in the past 5 years</b>			<b>Surgeries or Hospital Stays in the past 5 years</b>		
<p><b>Please circle or highlight in bold and underling:</b>                  High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke or TIA, Arthritis (Osteo or Rheumatoid), Diabetes (Type I, II), Osteoporosis (T-score _____), Cancer, Fibromyalgia, Anxiety, Depression, Chronic Fatigue:</p> <p><b>Explain:</b></p>			<p><b>Please circle or highlight in bold and underling:</b>                  High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke or TIA, Arthritis (Osteo or Rheumatoid), Diabetes (Type I, II), Osteoporosis (T-score _____), Cancer, Fibromyalgia, Anxiety, Depression, Chronic Fatigue:</p> <p><b>Explain:</b></p>		