PRELIMINARY QUESTIONNAIRE

NAME: Sex: M / F Age: Occupation:

If your answer is **yes**, please mark the empty box with an **"X"** and explain below. If your answer is **no**, leave blank and move to the next question.

X		X	
BARRIERS TO LEARNING:			
	Primary language other than English		Memory Deficit
	Impaired Vision		Cognitive Deficit
	Hard of Hearing		Lack of Interest
	Low Literacy skills		None
	Other:		
HOW DO YOU PREFER TO LEARN?			
	Reading		Hands-on (practicing)
	Watching a Video		Internet
	Listening		
MEDICAL HISTORY: Do you have or have you ever had			
	Back, disc problems, sciatic		*Heart disease
	HIV positive		*Congestive heart failure
	Tuberculosis or other lung disease		*Irregular heart beat
	Tumor or abnormal growth		*Heart surgery (angioplasty etc.)
	Asthma or other allergy		*Pressure or pain I chest, etc.
	Ulcers in stomach/intestines		*Swollen legs, ankles
	Disease of abdominal organs		*Breathlessness
	Communicable disease (specify)		*Stroke, vascular disease
	Arthritis		*Elevated blood pressure-note values
	Rheumatic fever – was heart affected?		*Epilepsy or other seizure disorders
	Kidney disease		*Nervous disorders
	Liver disease		*Gout
	General weakness		*Drug or alcohol abuse
	Frequent headaches		*Fainting episodes
	Vertigo		*Diabetes
	Thyroid or parathyroid disorders		Other prolonged/serious illness
	Nervousness, sleeplessness		Serious accident
	Disease of the eyes		Do you smoke?
	Disease of the ears		Osteoporosis
	Joint replacement		**If Female:**
	Anemia or other blood disorders		Breast cancer
	Hiatal hernia		*Currently pregnant
	Hepatitis		Disease of female organs
	Surgery		**If Male:**
	Incontinence		Prostate problems
	Cancer		
	Are you currently being treated for any illness **other** than the referred diagnosis?		

Comments: ______________________________

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MEDICATIONS: **Name/Type**	**Dosage**

Signature: Date: