GENERAL HEALTH QUESTIONNAIRE - CONFIDENTIAL DOCUMENT

Name____Tel.____________________________________

Address____

_____________________________________ Email ____

IT IS IMPORTANT THAT YOU DECLARE WHETHER YOU HAVE / HAVE HAD ANY OF THE FOLLOWING

Please **CIRCLE** any conditions which apply to you and **TICK BOXES**	YES	NO	MEDICATION?
STRUCTURAL DAMAGE : injuries, strains, sprains, broken bones, operations etc HEAD : NECK : SHOULDER: ARM : ELBOW : WRIST : HAND : BACK / SPINE : HIP : LEG ; KNEE : ANKLE : FOOT : OTHER... Brief information... .... Please discuss any condition with Judith to avoid aggravating a problem as some yoga poses may not be suitable			
HYPERTENSION (High Blood Pressure) **HYPOTENSION** (Low blood pressure)			
HEART DISEASE (e.g. Angina**)** **HEART ATTACK**................			
EPILESY - Minor / Major. **STROKE**			
MULTIPLE SCEROSIS **CANCER**			
Are you **HIV POSITIVE**			
EYE problems : **GLAUCOMA** **DETACHED RETINA** **Any other**........................			
EAR problems : **MENIERE'S DISEASE** **Any other**...			
DIABETES - Diet controlled / inject insulin **DIGESTIVE** Problems .... N.B. Ensure you bring medication to class			
CHRONIC FATIGUE SYNDROME : M.E.			
ALLERGIES N.B. Ensure you bring any medication to class			
ASTHMA **BRONCHIAL** Problems .... N.B. Ensure you bring medication to class			
NOSE BLEEDS **VARICOSE VEINS** **HEADACHES / MIGRAINES**			
Are you **PREGNANT** ?................................ Have you had a baby in the last 12 months?..................			
ANY OTHER CONDITION?			

DATE ....SIGNATURE...