BUILD

Client name: ______________________________ DOB: ____________________

1. Height: _______ ft. _______ in. Weight: _________________ lbs.

2. In the past 12 months, has client's weight changed more than 10 pounds?
   ☐ No
   ☐ Yes: Gain _____ lbs. Loss _____ lbs. Reason: ____________________________________

3. Has client ever had any weight loss reduction surgery?
   ☐ No
   ☐ Yes Please give details and date ____

4. Has client had any of the following? *(If any of the listed are checked off, request the specific questionnaire.)*

   ☐ Coronary artery disease

   ☐ Diabetes

   ☐ High blood pressure

   ☐ Elevated cholesterol or triglycerides (lipid levels)

5. Is client taking any medications? ☐No ☐Yes Please provide details below.

Medication Name <u>and</u> Dosage/Frequency	Start Date	Reason for Taking

6. Has a stress electrocardiogram (treadmill test) been completed within the past year?

   ☐ No

   ☐ Yes—normal Date: ____

   ☐ Yes—abnormal Date: ____

6. Are there any other health issues? ☐ No ☐ Yes: Please specify diagnosis and date.
   (Additional questionnaires may be required.)