Nutritional Survey

1. Are you currently taking nutritional supplements? Yes ☐ No ☐

2. If yes, where are they purchased? _____
   Which brand? _____
   How many times a day? _____

3. What supplements are you using?
   ☐ multivitamin ☐ antioxidants ☐ fish oils ☐ calcium ☐ others:
   _____

4. Where do you obtain information on nutritional supplements?
   ☐ news media ☐ friends and family ☐ your doctor ☐ internet
   ☐ other: _____

5. Are you currently taking prescription medication? Yes ☐ No ☐
   Please list: _____

6. How would you classify this statement.:
   All vitamins/nutritional supplements are created equal.
   ☐ True ☐ False ☐ Don't know

CARDIOVASCULAR HEALTH SURVEY

1.	Do you have a family history of heart disease or diabetes?	Yes ☐	No ☐
2.	Have you been diagnosed with heart disease or diabetes?	Yes ☐	No ☐
3.	Do you take cholesterol-lowering medications?	Yes ☐	No ☐
4.	Have you been diagnosed with Metabolic Syndrome?	Yes ☐	No ☐
5.	Are you overweight?	Yes ☐	No ☐
6.	Do you have low HDL-good cholesterol?	Yes ☐	No ☐
7.	Do you have high LDL-the bad cholesterol?	Yes ☐	No ☐
8.	Do you have high triglycerides?	Yes ☐	No ☐

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING CONDITIONS?

☐ Fatigue	☐ Skin conditions	☐ Digestive problems
☐ Anxiety	☐ Depression	☐ Sleep problems
☐ Loss of weight/appetite	☐ Weight gain	☐ Numbness
☐ Tingling of hands or feet	☐ Bruising	☐ Muscle weakness
☐ Muscle cramping	☐ Reduced muscle mass	☐ Nausea
☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Heart spasms	☐ Hair loss	☐ Slow wound healing