

Lifestyle and Health-history Questionnaire

Name: _____ Date: _____ Date of birth: _____

Medical Information

1. How would you describe your present state of health?

Very well Healthy Unhealthy Ill Other: _____

2. List current medications, how often you take them, and dosages (include prescriptions and over-the-counter medications). _____

3. Do you take all of your medications as they have been prescribed by your healthcare provider? Yes No

If not, please share why (e.g., cost, side effects, or feeling as though they are unnecessary). _____

4. Do you take any vitamin, mineral, or herbal supplements? Yes No

If yes, list type and amount per day: _____

5. When was the last time you visited your physician? _____

6. Have you ever had your cholesterol checked? Yes No

Date of test: _____ What were the results? _____

Total cholesterol: _____ High-density lipoprotein (HDL): _____ Low-density lipoprotein (LDL): _____

Triglycerides: _____

7. Have you ever had your blood sugar checked? Yes No

What were the results? _____

8. Please check any that apply to you and list any important information about your condition:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies (Specify: _____) | <input type="checkbox"/> Disordered eating | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Major surgeries: _____
_____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypo/hyperthyroidism | <input type="checkbox"/> Past injuries: _____
_____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Describe any other health conditions that you have:

_____ |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Intestinal problems | |
| <input type="checkbox"/> Chronic sinus condition | <input type="checkbox"/> Irritability | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Irritable bowel syndrome (IBS) | |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Menopausal symptoms | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Premenstrual syndrome (PMS) | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Polycystic ovary syndrome (PCOS) | |

Family History

1. Has anyone in your immediate family been diagnosed with the following?

- | | | |
|--|-------------------------------------|-------------------------|
| <input type="checkbox"/> Heart disease | If yes, what is the relation? _____ | Age of diagnosis: _____ |
| <input type="checkbox"/> High cholesterol | If yes, what is the relation? _____ | Age of diagnosis: _____ |
| <input type="checkbox"/> High blood pressure | If yes, what is the relation? _____ | Age of diagnosis: _____ |
| <input type="checkbox"/> Cancer | If yes, what is the relation? _____ | Age of diagnosis: _____ |
| <input type="checkbox"/> Diabetes | If yes, what is the relation? _____ | Age of diagnosis: _____ |
| <input type="checkbox"/> Osteoporosis | If yes, what is the relation? _____ | Age of diagnosis: _____ |

Nutrition

1. What are your dietary goals? _____

2. Have you ever followed a modified diet? Yes No

If yes, describe: _____

3. Are you currently following a specialized eating plan (e.g., low-sodium or low-fat)? Yes No

If yes, what type of eating plan? _____

4. Why did you choose this eating plan? _____

Was the eating plan prescribed by a physician? Yes No

How long have you been on the eating plan? _____

5. Have you ever met with a registered dietitian or attended diabetes education classes? Yes No

Are you interested in doing so? Yes No

6. What do you consider to be the major issues with your nutritional choices or eating plan (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety)? _____

7. How many glasses of water do you drink per day? _____ 8-ounce glasses

8. What do you drink other than water? List what and how much per day. _____

9. Do you have any food allergies or intolerance? Yes No

If yes, what? _____

10. Who shops for and prepares your food? Self Spouse Parent Minimal preparation

11. How often do you dine out? _____ times per week

12. Please specify the type of restaurants for each meal:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

13. Do you crave any foods? Yes No

If yes, please specify: _____

Habits

1. Do you drink alcohol? Yes No If yes, how often? _____ times per week Average amount? _____
2. Do you drink caffeinated beverages? Yes No If yes, average number per day: _____
3. Do you use tobacco? Yes No If yes, how much (cigarettes, cigars, or chewing tobacco per day)? _____

Physical Activity

1. Do you currently participate in any structured physical activity? Yes No

If so, please describe:

_____ minutes of cardiorespiratory activity, _____ times per week

_____ strength-training sessions per week

_____ flexibility-training sessions per week

_____ minutes of sports or recreational activities per week

List sports or activities you participate in: _____

2. Do you engage in any other forms of regular physical activity? Yes No

If yes, describe: _____

3. Have you ever experienced any injuries that may limit your physical activity? Yes No

If yes, describe: _____

4. Do you have any physical-activity restrictions? If so, please list: _____

5. What are your honest feelings about exercise/physical activity? _____

6. What are some of your favorite physical activities? _____

Occupational

1. Do you work? Yes No

If yes, what is your occupation? _____

If you work, what is your work schedule? _____

2. Describe your activity level during the work day: _____

Sleep and Stress

1. How many hours of sleep do you get at night? _____

2. Rate your average stress level from 1 (no stress) to 10 (constant stress) _____

3. What is most stressful to you? _____

4. How is your appetite affected by stress? Increased Not affected Decreased

Weight History

1. What would you like to do with your weight? Lose weight Gain weight Maintain weight

2. What was your lowest weight within the past 5 years? _____

3. What was your highest weight within the past 5 years? _____

4. What do you consider to be your ideal weight (the sustainable weight at which you feel best)? _____ Don't know

5. What is your present weight? _____ Don't know

6. What are your current waist and hip circumferences? _____ Waist _____ Hip Don't know

7. What is your current body composition? _____% body fat Don't know

Goals

1. On a scale of 1 to 10, how ready are you to adopt a healthier lifestyle (1 = very unlikely; 10 = very likely)? _____

2. Do you have any goals for improving your health? Yes No If yes, please list them in order of importance.

3. Do you have a weight-loss goal? Yes No

If yes, what is it? _____

4. Why do you want to lose weight?

