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:

☐ Allergies (Specify: ________)  ☐ Disordered eating  ☐ Pregnant

☐ Amenorrhea  ☐ Gastroesophageal reflux disease (GERD)  ☐ Skin problems

☐ Anemia  ☐ High blood pressure  ☐ Ulcer

☐ Anxiety  ☐ Hypoglycemia  ☐ Major surgeries: __________________________________________

☐ Arthritis  ☐ Hypo/hyperthyroidism  ☐ Past injuries: __________________________________________

☐ Asthma  ☐ Insomnia  ☐ Describe any other health conditions that you have:

☐ Celiac disease  ☐ Intestinal problems  __________________________________________

☐ Chronic sinus condition  ☐ Irritability  __________________________________________

☐ Constipation  ☐ Irritable bowel syndrome (IBS)  __________________________________________

☐ Crohn’s disease  ☐ Menopausal symptoms  __________________________________________

☐ Depression  ☐ Osteoporosis  __________________________________________

☐ Diabetes  ☐ Premenstrual syndrome (PMS)  __________________________________________

☐ Diarrhea  ☐ Polycystic ovary syndrome (PCOS)  __________________________________________
Family History

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

- ☐ Heart disease  If yes, what is the relation? ___________________________  Age of diagnosis: _________
- ☐ High cholesterol  If yes, what is the relation? ___________________________  Age of diagnosis: _________
- ☐ High blood pressure  If yes, what is the relation? ___________________________  Age of diagnosis: _________
- ☐ Cancer  If yes, what is the relation? ___________________________  Age of diagnosis: _________
- ☐ Diabetes  If yes, what is the relation? ___________________________  Age of diagnosis: _________
- ☐ 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?
   __________________________________________________________________________
   __________________________________________________________________________