SAMPLE 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  □ Unwell  □ 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: ___________)
   □ Amenorrhea
   □ Anemia
   □ Anxiety
   □ Arthritis
   □ Asthma
   □ Celiac disease
   □ Chronic sinus condition
   □ Constipation
   □ Crohn’s disease
   □ Depression
   □ Diabetes
   □ Diarrhea
   □ Disordered eating
   □ Gastroesophageal reflux disease (GERD)
   □ High blood pressure
   □ Hypoglycemia
   □ Hypo/hyperthyroidism
   □ Insomnia
   □ Intestinal problems
   □ Irritability
   □ Irritable bowel syndrome (IBS)
   □ Menopausal symptoms
   □ Osteoporosis
   □ Premenstrual syndrome (PMS)
   □ Polycystic ovary syndrome (PCOS)
   □ Pregnant
   □ Skin problems
   □ Ulcer
   □ Major surgeries: _________________
   ____________________________
   ____________________________
   □ Past injuries: _________________
   ____________________________
   ____________________________
   □ Describe any other health conditions that you have: __________
   ____________________________
   ____________________________
   ____________________________

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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
   If 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: ____________________________________________________

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Substance-related 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
   _______ muscular-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 is your present weight? _________  □ Don't know
2. What would you like to do with your weight?  □ Lose weight  □ Gain weight  □ Maintain weight
3. What was your lowest weight within the past 5 years? _________
4. What was your highest weight within the past 5 years? _________
5. What do you consider to be your ideal weight (the sustainable weight at which you feel best)? _________  □ 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 likely are you to adopt a healthier lifestyle (1 = very unlikely; 10 = very likely)? _________
2. Do you have any specific 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?
   __________________________________________________________________________________________
   __________________________________________________________________________________________