



LIFESTYLE AND HEALTH-HISTORY QUESTIONNAIRE

MEDICAL INFORMATION

- How would you describe your present state of health? very well healthy unhealthy ill other: _____
- Are you taking any prescription medication? Yes No
If yes, what medications and why? _____
Do these interact with foods or weight loss in any way? _____
- Do you take any over-the-counter medication? Yes No
If yes, what medications and why? _____
- When was the last time you visited your physician? _____
- Have you ever had your cholesterol checked? Yes No
Date of test: _____ What were the results?
Total Cholesterol: _____ HDL: _____ LDL: _____ TG: _____
- Have you ever had your blood sugar checked? Yes No
What were the results? _____
- Please check any that apply to you and list any important information about your condition:

<input type="checkbox"/> Allergies (Specify: _____)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Premenstrual syndrome (PMS)
<input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Disordered eating	<input type="checkbox"/> Polycystic ovary syndrome (PCOS)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gastroesophageal reflux disease (GERD)	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Anxiety	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypo/hyperthyroidism	<input type="checkbox"/> Major surgeries: _____
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Past injuries: _____
<input type="checkbox"/> Chronic sinus condition	<input type="checkbox"/> Intestinal problems	<input type="checkbox"/> Describe any other health conditions that you have: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Irritability	_____
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Irritable bowel syndrome (IBS)	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Menopausal symptoms	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	_____

FAMILY HISTORY

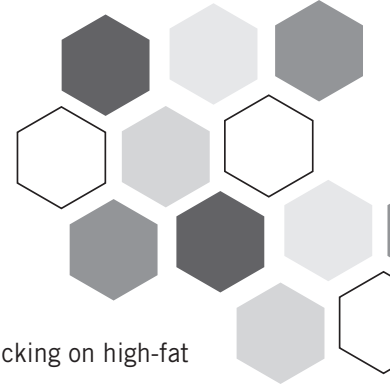
- Has anyone in your immediate family been diagnosed with the following?

<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: _____
- What are your dietary goals? _____
- Have you ever followed a modified diet? Yes No
If so, describe: _____
- Are you currently following a specialized diet (e.g., low-sodium or low-fat)? Yes No
If so, what type of diet? _____

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Note: HDL = High-density lipoprotein; LDL = Low-density lipoprotein; TG = Triglycerides





12. Why did you choose this diet? _____
 Was the diet prescribed by a physician? Yes No
 How long have you been on the diet? _____
13. Have you ever met with a registered dietitian? Yes No
 Are you interested in meeting with one? Yes No
14. What do you consider to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety) _____
15. How many glasses of water do you drink per day? _____ 8-ounce glasses
16. Do you have any food allergies or intolerance? Yes No
 If so, what? _____
17. Who prepares your food? Self Spouse Parent Minimal preparation
18. How often do you dine out? _____ times per week
19. Please specify the type of restaurants for each meal:
 Breakfast: _____ Lunch: _____
 Dinner: _____ Snacks: _____

HABITS

20. Do you crave any foods? Yes No
 If so, please specify: _____
21. How is your appetite affected by stress? increased not affected decreased
22. Do you drink alcohol? Yes No How often? _____ times per week Average amount? _____ glasses
23. Do you drink caffeinated beverages? Yes No Average number per day: _____
24. Do you use tobacco? Yes No How much (cigarettes, cigars, or chewing tobacco per day)? _____
25. Do you take any vitamin, mineral, or herbal supplements? Yes No
 Please list type and amount per day: _____
26. Do you currently participate in any structured physical activity? Yes No
 If so, please describe: _____ minutes of cardiovascular activity, _____ times per week
 _____ strength-training sessions, _____ times per week
 _____ minutes of flexibility training, _____ times per week
 _____ minutes of sports per week

 List sports: _____
 Do you engage in any other forms of regular physical activity? _____
 Please describe your activity level during the work day: _____
27. Have you experienced any injuries that may limit your physical activity?
 If so, please describe: _____
28. On a scale of 1–10, how ready are you to adopt a healthier lifestyle? 1 = very unlikely 10 = very likely _____

WEIGHT HISTORY

29. What would you like to do with your weight? lose weight gain weight maintain weight
30. What was your lowest weight within the past 5 years? _____ lb
31. What was your highest weight within the past 5 years? _____ lb
32. What do you consider to be your ideal weight (the weight at which you feel best)? _____ lb don't know
33. What is your present weight? _____ lb
34. What are your current waist and hip circumferences? _____ waist _____ hip don't know
35. What is your present body composition? _____ % body fat don't know

