Health & Lifestyle Questionnaire

A. Personal Information

1. Name:_____ 2. Date:_____

3. Address_____

_____

4. Phone Numbers (please circle preferred contact number)

a. Home:_____

b. Office:_____

c. Cell:_____

5. Confidential e-mail (to send you confidential medical information):_____

_____

6. Confidential fax (to send you confidential medical information):_____

7. Sex:_____Male _____Female 8. Height:_____

9. Weight:

a. Current Weight:_____

b. Lowest Adult Weight:_____

c. Highest Adult Weight:_____

10. Frame Size: _____Small _____Medium _____Large

11. Blood Type: _____

12. Personal Physician (and phone number):

13. Date of Birth: _____ 14. Age:_____

15. Marital Status: _____Single _____Married _____Divorced _____Widowed

16. Who lives with you in your household?

17. How many children do you have?

18. What is your current occupation?

19. How would you rate your current health?

_____Poor _____Average _____Good _____Excellent

20. What are your health related goals?

21. What are your most important expectations as a patient?

B. Medical History

Condition	Does Not Apply	Myself	Siblings	Parents	Grand Parents
1. Heart Disease					
2. Cancer					
3. Diabetes					
4. High Blood Pressure					
5. Arthritis					
Condition	Does Not Apply	Myself	Siblings	Parents	Grand Parents

6. Liver Disease (hepatitis, cirrhosis, etc.)					
7. Psychiatric Illness (depression, anxiety, psychotic disorders, etc.)					
8. Autoimmune disease (lupus, rheumatoid arthritis, etc.)					
9. Endocrine Gland Disorders (thyroid, adrenal, pituitary)					
10. Neurological Disorders (stroke, seizures, Parkinson's Alzheimer's, multiple sclerosis, etc.)					
11. Lung Disease (asthma, emphysema, bronchitis, etc.)					
12. Kidney Disease (stones, infections, cysts, etc.)					
13. Stomach/Esophagus Disorders (reflux, stricture, ulcers, etc.)					
14. Bowel Disease (Malabsorption, lactose intolerance, diverticulitis, Crohn's colitis, etc.)					
15. Bladder disease					
16. Substance Abuse (alcohol, prescription or recreational drugs, tobacco)					
17. Weight Control Problems					
18. Osteoporosis/Weak Bones					
19. Migraine Headaches					
20. Anemia					
21. HIV/AIDS					
22. Allergies					
23. Memory Problems					
24. Sleep Apnea/Snoring					

Please check the column that applies to each question. Feel free to leave blank any questions you don't understand or wish to discuss in private:

25. Please provide an explanation for any items for which you checked “Myself”_____

_____

_____

_____

_____

_____

_____

_____

26. Please list any surgical procedures you have had (including plastic surgery), along with the approximate date: _____

_____

_____

_____

_____

27. Please list any history of trauma that you have experienced (car accidents, head injuries, broken bones, etc.):_____

_____

_____

_____

28. Please list any drug allergies you have, along with the reaction you experienced:

_____

_____

_____

29. Please list any exposure you have experienced to environmental risks:

Exposure	When?	Length of Exposure?
a. Asbestos		
b. Coal dust		
c. Chemicals		
d. Sun/tanning		
e. Fumes/gasses		
f. Radon testing		
g. X-ray treatments		
h. Other (Please List):		

Procedure	When?	For what Reason?

30. Please list any diagnostic procedures you have had: 31. Have you ever had a transfusion? If so, please list when and for what reason: _____

_____

_____

32. Please list all the medications (prescription and/or over-the-coater) you are currently taking and for what condition:

Medication	For what condition?	Dose (mg):	Times per day:

Supplement	For what condition?	Dose (mg):	Times per day:

33. Please list all supplements (vitamins, herbs, nutritional supplements) you are currently taking and for what condition or you can copy labels and send in with questionnaire: 34. Please describe any current recreational drug use:

35. Are you currently receiving?: Radiation Therapy Chemotherapy

a. If yes, for what?

C. Current Symptoms

For the following categories, please check the symptoms that you are experiencing to a degree that you feel <u>is substantial or unusual</u>

1. Skin and Hair

Symptom:	YES	NO
a. Dry/brittle and/or flaky hair		
b. Dry/brittle skin		
c. Acne		
d. Age Spots		
Symptom:	YES	NO

e. Thick skin and fingernails		
f. Puffy, wrinkled skin		
g. Dark circles under eyes		
h. Hair thinning or falling out or hair grows very slowly		
i. Toe or fingernail fungus		
j. Bumpy skin on face or backs of arms		
k. Spider veins in nose and/or face		
l. Persistent rash/skin allergy		
m. Hives		
n. Sores, boils, or sties		
o. Slow or poor wound healing		
p. Excessive sweating or itching		
q. Flushing or hot flashes		
r. Bruise easily or excessively		

2. Allergies

Symptom	YES	NO
a. Drug allergies (please list, along with description of reaction)		
b. Seasonal allergies (please describe symptoms):		
c. Food allergies (please list, along with description of reaction)		
d. Latex allergy (please describe reaction):		

3. Cardiopulmonary

Symptom	YES	NO
a. Pain in the left side under the rib cage		
b. Pain in the right side under the rib cage		
c. Pain in the left arm		
d. Chest pain while walking		

Symptom	YES	NO
e. Frequent and recurring upper respiratory infections or colds/flu		
f. Fluid retention (e.g., swollen ankles, legs, etc.)		
g. Cannot tolerate much exercise		
h. Difficulty breathing		
i. Chronic lung congestion		
j. Wheezing		
k. Heaviness in legs		
l. Calf muscle cramps while walking		
m. Heart pounds easily		
n. Heart misses beats or has extra beats		
o. Rapid heartbeat, fluttering		
p. Shortness of breath		
q. Heartburn after eating		
r. Exhaustion with minor exertion		
s. Erratic blood pressure		
t. High blood pressure		
u. Low blood pressure		
v. Other pain in chest or sides		
w. Breathing problems at night		
x. Difficulty lying flat		

4. Metabolic

Symptom	YES	NO
a. Certain foods cause ill feelings		
b. Difficulty gaining weight		
c. Difficulty losing weight		
d. Bad breath (no relief by brushing)		

e. Body odor (no relief by washing)		
Symptom	YES	NO
f. Total blood cholesterol above 200		
g. HDL cholesterol below 50		
h. LDL cholesterol above 130		
i. Swollen (bulging) eyes		
j. Hypersensitive to the cold		
k. Cold hands and feet		
l. Thinning or loss of outside portion of eyebrow		
m. Gain weight easily		
n. Body temperature below 97.6 F		
o. Crave salt or salty foods		
p. Blushing with no apparent cause		
q. Irritable if meal is missed		
r. Wake up in the middle of the night craving sweets		
s. Feel tired or weak if meal is missed		
t. Heart palpitations after eating sweets		
u. Need to drink caffeine to get going		
v. Feel tired 1 to 3 hours after eating		
w. Feel faint or weak		
x. Night sweats		
y. Increase thirsts		
z. Overweight		
aa. Crave sweets (but eating sweets does not relieve symptoms)		
bb. Sugar in urine		
cc. Weight loss of more than 10 lbs. in the last six months		
dd. Weight gain of more than 10 lbs. in the last six months		
ee. Weight has stayed consistent over last five years		

5. Kidney, Bowels, Bladder and Gastrointestinal

Symptom	YES	NO
a. Frequent urination or scant urination/dribbling		
b. Burning during urination		
c. Loss of bladder control (including leaking)		
d. Hemorrhoids		
e. Excessive nighttime urination (specify number of times)		
f. Loss of bowel control		
g. Blood in urine		
h. Blood in stool		
i. Kidney stones		
j. Frequent urinary tract infections		
k. Diarrhea		
l. Constipation (hard or effortful bowel movements)		
m. Difficulty urinating		
n. Abdominal pain		
o. Nausea and/or vomiting		
p. Heartburn/reflux		
q. Difficulty swallowing or pain with swallowing		
r. Flatulence (gas) or bloating		
s. Gallbladder problems		
t. Dependency on Antacids		

6. Neurological

Symptom	YES	NO
a. Headaches		
b. Faintness		

c. Seizures/convulsions		
d. Tremors		
Symptom	YES	NO
e. Dizziness		
f. Tingling or numbness		
g. Balance problems		
h. Paralysis		
i. Muscle weakness		
j. Uncoordinated		
k. Difficulty walking		
l. Difficulty speaking		
m. Memory problems		
n. Loss of smell or taste		
o. Problems with attention and concentration		

7. Eyes, Ears, Nose and Throat

Symptom	YES	NO
a. Change in vision		
b. Blurred or tunnel vision		
c. Double vision		
d. Balance problems		
e. Hearing loss		
f. Ringing in ears		
g. Ear pain		
h. Ear drainage		
i. Nosebleeds		
j. Stuffy nose		
k. Sore throat/hoarseness		

l. Sinus infections		
m. Sore or bleeding gums		
n. Canker sores or cold sores		

8. Joints, Muscle and Bone

Symptom	YES	NO
a. Joint pain, swelling or stiffness		
b. Arthritis		
c. Back pain		
d. Limited motion		
e. Muscle tension or spasms		
f. Fibromyalgia		
g. Carpal Tunnel Syndrome		

9. Mind and Emotions

Symptom	YES	NO
a. Rapid mood swings		
b. Impatient, moody, nervous		
c. Lack of mental alertness		
d. Depression		
e. Anxiety/fear		
f. Lack of self-esteem		
g. Difficulty with memory, attention, or concentration		
h. Short attention span		
i.. Personality changes		
j. Sleep disturbances		
k. Short temper/anger/irritability		
l. Excessive worrying		

m. Suicidal thoughts		
n. Confusion/poor comprehension		
o. Difficulty making decisions		
p. Excessive stress		
Symptom	YES	NO
q. Restlessness, hyperactivity, or inability to relax		
r. Weakness, fatigue, or loss of energy		
s. Frequent infections		

10. Miscellaneous

Symptom	YES	NO
a. Frequent infections or illness		
b. Change in appetite		
c. Fatigue		
d. Apathy/lethargy		
e. Lumps in neck, armpits, groin or breast		
f. Broken bone as adult		
g. Insomnia		
h. Hypersomnia (sleeping too much)		
i. Sleep Apnea		
j. Other symptoms (please list)		

12. For Women Only

Symptom	YES	NO
a. Missed periods		
b. Pelvic or vaginal soreness or pain		
c. Menstrual pain		
d. Heavy menstrual bleeding		
e. Irregular periods		
f. Infertility		
g. Hot flashes/night sweats		
h. Underachieve sex drive		
i. Overactive sex drive		
j. Pre-menstrual syndrome (PMS)		
k. Monthly weight gain		
l. Bloating and swelling		
m. Tender breasts		
n. Low backache		
o. Vaginal itching		
p. Vaginal discharge or sores		
q. Past or present sexually transmitted disease (specify):		
r. Dislike or intercourse		
s. Pain in ovaries		
t. Water retention		
u. Craving for sweets		
v. Sweating throughout the day		
w. Vaginal dryness		
x. History of miscarriages		
y. History of ovarian cysts		
z. History of uterine cysts/fibroids		
aa. History of endometriosis		

Symptom	YES	NO
bb. Date of last menstrual period		
cc. Have you had a hysterectomy? If yes, why and when?		
dd. Form of birth control: None Pill JUD Sponge Diaphragm Foam Condoms Tubal Ligation or Hysterectomy		
ee. Date of last pap smear/pelvic exam		
ff. Date of last breast exam:		
gg. Date of last mammogram:		
hh. Date of last colonoscopy (or sigmoidoscopy)		
ii. Date of last rectal exam:		
jj. Date of last stress EKG (Treadmill Stress Test):		
kk. Date of last chest X-ray:		
ll. Date of last eye exam/eye pressures:		

D. Lifestyle Summary

1. How many alcoholic beverages do you consume in an average week (including beer and wine)?	2. For Past and present tobacco users: a. Do you currently use tobacco? Y_____N_____ b. If yes, what type?_____ c. How much per day?_____ d. If you previously used tobacco - what did you use? e. How much per day on average? f. For how long? g. When did you quit? h. How many times have you quit?
3. What are your hobbies?	
4. Do you travel outside the country? Y_____ N_____ If yes, please list countries you have visited in the last 5 years	
5. Do you consider yourself to be under a great deal of stress? Please explain:	
6. Do you use a seat belt: Always Sometimes Most of the time Never	

7. Do you have guns in your home? If yes, are they loaded? If yes, do you keep them locked up?	Y_____ N_____ Y_____ N_____ Y_____ N_____
8. Do you have a working smoke detector?	Y_____ N_____
9. Do you have a working carbon monoxide detector?	Y_____ N_____
10. At what temperature do you keep your water heater?	

E. Exercise Summary

1. How often do you engage in aerobic exercise (walking, jogging, biking, swimming)?
    a. Times per week:_____
    b. Length of each exercise period:_____
    c. Please describe your routine:_____

_____

_____

_____

2. How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch and toning classes, brief stretching after aerobics or weights)?
    a. Times per week:_____
    b. Length of each exercise period:_____
    c. Please describe your routine:_____

_____

_____

_____

3. How often do you participate in resistance/strength training exercises (free weights, weight machines, body pump classes, water aerobics)?
    a. Times per week:_____
    b. Length of each exercise period:_____
    c. Please describe your routine:_____

_____

_____

_____

Question	YES	NO
a. Are you currently involved in an exercise program?		
b. Hove you ever been a member of a health club?		
c. If yes, for how long?		
d. Are you currently a member of a health club?		
e. Have you ever worked with a personal trainer?		

f. If yes, for how long? Did you enjoy it?		
g. Are you still with a personal trainer?		
Question	YES	NO
h. Do you have any exercise equipment at home (bike, treadmill, free weights, etc.)? If yes, please list:		
i. Are you presently receiving physical therapy?		
j. If yes, please describe:		
k. If exercise is not in your weekly routine, please explain why:		

F. Dietary Summary

1. How many cups of tea do you drink a day?	2. How many cups of coffee do you drink a day?
3. How many diet sodas or other drinks with aspartame do you drink a day?	4. How many 8 oz. glasses of water do you drink a day?
5. How many high sugar foods do you eat a day (Cake, cookies, breads, pasta, etc.)?	

6. Are you a vegetarian? Y_____ N_____

If yes, what type?

a. Vegan (Plant products only)
b. Lactovegetarian (Plant and dairy products)
c. Ovolactovegetarian (Plant, dairy and egg products)
d. Fruitarian (fruits, nuts, honey, and vegetables only)

7. Food Summary

In order to accurately assess your current nutrient and calorie intake we need to get an idea of your eating habits. Please fill out the food logs on the following pages in detail for what you consider your average healthy eating day and your average unhealthy eating day. This will give us an idea of your strengths and weaknesses and help us make suggestions for positive change

Please be specific with portion sizes. If you don't know how many ounces, or cups, something is, give us a reference. For example: 1 large apple (baseball sized), broiled chicken (about the size of two decks of cards). Giving us these references will help us estimate your serving sizes.

Add in any extras you may consume such as cream or sugar in your coffee, after dinner mints, nibbles of baked goods or candy. DON'T FORGET TO LIST BEVERAGES! (coffee, water, diet

soda, green tea, etc.) Be as thorough as you can. The more accurate you are, the better we can assist you in creating improvements in your diet. List how you truly eat, not how you plan to eat.

If you would prefer to keep a 3-5 day food log instead of using this form, that would be acceptable as well.

Meal/Snack and Times	Food or Beverage	Portion Size or estimation	Grams of Protein (P), Carbohydrates (C), and Fat (F) if known. If not known, please leave blank		
			P	C	F
1. Breakfast Time:_____					
2. AM Snack Time:_____					
3. Lunch Time:_____					
4. Midday Snack Time:_____					
5. Dinner Time:_____					
6. PM Snack Time:_____					
Other Time:_____					

8. Do you have any specific problem foods you consistently overeat? YES NO

Problem Food	How often do you overeat this food? (daily, weekly, monthly)
1	
2	
3	
4	
5	
6	
7	

8	
9	

a. If yes, Please describe

9. Have you noticed any situation, moods, or occasions that cause you to eat or drink more than you should (e.g., when you are stressed)? YES NO

a. If yes, please Describe:_____

_____

_____

_____

_____

_____

_____

H. Holmes-Rahe Life Changes Scale

Please review the events below. Beside each one, indicate the number of times each event occurred in the past year only.

EVENT	# of times in past year
1. Death of a spouse	
2. Divorce	
3. Marital separation	
4. Jail term	
5. Death of a close family member	
6. Personal injury or illness	
7. Marriage	
8. Fired from work	
9. Marital reconciliation	
10. Retirement	
11. Change in health of a family member	
12. Pregnancy	
13. Sexual difficulties	
14. Gain of a new family member	
15. Business readjustment	
16. Change in financial state	

17. Death of a close friend	
18. Change to a different line of work	
19. Change in number of arguments with spouse	
EVENT	# of times in past year
20. Mortgage over $100,000	
21. Foreclosure of mortgage or loan	
22. Change in responsibilities at work	
23. Son or Daughter leaving home	
24. Trouble with in-laws	
25. Outstanding personal achievement	
26. Spouse began or stopped work	
27. Began or ended school	
28. Change in living conditions	
29. Revision of personal habits	
30. Trouble with the boss	
31. Change in work hours or conditions	
32. Change in residence	
33. Change in schools	
34. Change in recreation	
35. Change in religious activities	
36. Change in social activities	
37. Change in sleeping habits	
38. Change in eating habits	
39. Change in number of family get-togethers	
40. Vacations	
41. Religious holidays	
42. Minor violations of the law	