

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

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

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

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

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

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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: \_\_\_\_\_

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

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 is substantial or unusual

1. Skin and Hair

2. Allergies

3. Cardiopulmonary

4. Metabolic

5. Kidney, Bowels, Bladder and Gastrointestinal

6. Neurological

7. Eyes, Ears, Nose and Throat

8. Joints, Muscle and Bone

9. Mind and Emotions

10. Miscellaneous

11. For Men Only

12. For Women Only

D. Lifestyle Summary

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: \_\_\_\_\_

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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: \_\_\_\_\_

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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: \_\_\_\_\_

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F. Dietary Summary

6. Are you a vegetarian? Y\_\_\_\_\_ N\_\_\_\_\_

If yes, what type?

1. Vegan (Plant products only)
2. Lactovegetarian (Plant and dairy products)
3. Ovolactovegetarian (Plant, dairy and egg products)
4. 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.

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

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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.