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: _____
   _____
   _____
   _____
   _____

Continued on the next page

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: _____

Continued on the next page

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? _____

   _____

   _____

Continued on the next page

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?

_____

_____