Wellness & Preventive Care Questionnaire

This questionnaire helps Dr. Ramirez understand your wellness habits and preventive care needs. Please answer honestly to support your personalized care plan.

GENERAL INFORMATION

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Wellness & Preventive Care Questionnaire

LIFESTSTYLE & DAILY HABITS

1. Describe your typical daily diet:

_____

2. Daily servings of fruits/vegetables:

_____

3. Daily water intake (glasses):

_____

4. Do you drink caffeine? Amount per day:

_____

5. Do you drink alcohol? Frequency/amount:

_____

6. Do you smoke or vape? Frequency:

_____

Wellness & Preventive Care Questionnaire

EXERCISE & PHYSICAL ACTIVITY

7. How often do you exercise per week?

_____

8. What types of exercise do you do?

_____

9. Any physical limitations or chronic pain?

_____

SLEEP & REST

10. Average hours of sleep per night:

_____

11. Trouble falling or staying asleep?

_____

12. Do you wake up feeling rested?

_____

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STRESS & MENTAL WELL-BEING

13. Rate your stress level (1–10):

_____

14. Biggest sources of stress:

_____

15. Do you experience anxiety or depression?

_____

16. Do you practice relaxation techniques?

_____

PREVENTIVE CARE

17. Last annual physical:

_____

18. Last bloodwork (labs):

_____

19. Vaccinations up to date?

_____

20. Family history of major conditions:

_____

Patient Signature:

_____

Date:

_____