Lifestyle and Health History Questionnaire

MEDICAL INFORMATION

1. How would you describe your present state of health? ❑ very well ❑ healthy ❑ unhealthy ❑ ill ❑ other:____________

2. 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?____________

3. Do you take any over-the-counter medication? ❑ Yes ❑ No
   If yes, what medications and why?____________

4. When was the last time you visited your physician?____________

5. Have you ever had your cholesterol checked? ❑ Yes ❑ No
   Date of test:____________ What were the results?
   Total Cholesterol:____________ HDL:____________ LDL:____________ TG:____________

6. Have you ever had your blood sugar checked? ❑ Yes ❑ No
   What were the results?____________

7. 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
   ❑ Ulcer
   ❑ Skin problems
   ❑ Major surgeries: ____________
   ❑ Past injuries: ____________
   ❑ Describe any other health conditions that you have:____________
   ____
   ____
   ____
   ____

FAMILY HISTORY

8. 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:____________

9. What are your dietary goals?____________

10. Have you ever followed a modified diet? ❑ Yes ❑ No
    If so, describe:____________

11. Are you currently following a specialized diet (e.g., low-sodium or low-fat)? ❑ Yes ❑ No
    If so, what type of diet?____________

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