Lifestyle & Health-History Questionnaire

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) Family History:

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: _____

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
❑ Irritable bowel syndrome (IBS) ❑Menopausal symptoms ❑Osteoporosis
❑Polycystic ovary syndrome (PCOS)❑Ulcer ❑Skin problems
❑ Major surgeries: _____
❑ Past injuries: _____
❑ Describe any other health conditions that you have:

Nutrition

9. What are your dietary goals?

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

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

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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, lack of variety)

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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?

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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:

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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:

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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:

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27. Have you experienced any injuries that may limit your physical activity? If so, please describe:

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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