Name_____ DOB_____

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?_____

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Note: HDL = High-density lipoprotein; LDL = Low-density lipoprotein; TG = Triglycerides

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