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? (Circle one). YES NO
If not, please share why (eg., cost, side effects, or feeling as though they are unnecessary).

_____
_____
_____

4. Do you take any vitamin, mineral, or herbal supplements: (Circle one)
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? (Circle one) 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? (Circle one). YES NO

What were the results?

_____

8. Please circle any that apply to you and list any important information about your condition:

Allergies (Specify: _____)	High Blood Pressure
Amenorrhea	Hypoglycemia
Anemia	Hypo/hyperthyroidism
Anxiety	Insomnia
Arthritis	Intestinal problems
Asthma	Irritability
Celiac disease	Irritable Bowel Syndrome (IBS)
Chronic sinus condition	Menopausal symptoms
Constipation	Osteoporosis
Crohn's disease	Premenstrual syndrome (PMS)
Depression	Polycystic ovary syndrome
Diabetes	Pregnant
Diarrhea	Skin problems
Disordered eating	Ulcer
Gastroesophageal reflux disease (GERD)	

Major surgeries:

_____

Past injuries:

_____

Describe any health conditions you have:

_____

_____

_____

Family History

1. Has anyone in your immediate family been diagnosed with the following?

- ☐ Heart disease What is the relation?_____ Age of diagnosis:___
- ☐ High cholesterol What is the relation?_____ Age of diagnosis:___
- ☐ High blood pressure What is the relation?_____ Age of diagnosis:___
- ☐ Cancer What is the relation?_____ Age of diagnosis:___
- ☐ Diabetes What is the relation?_____ Age of diagnosis:___
- ☐ Osteoporosis What is the relation?_____ Age of diagnosis:___

Nutrition

Lifestyle and Health History Questionnaire

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 (eg., low-sodium, 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 or registered dietician?
   YES NO
   How long have you been on the eating plan?_____
5. Have you ever met with a registered dietician or attended a diabetes education class?
   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 (eg., 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 intolerances? YES NO
   If yes, what?_____
10. Who shops and prepares your food? Self Spouse Parent Minimal prep
11. How often do you dine out? _____ times per week
12. Please specify type of restaurant for each meal:
    Breakfast:_____ Lunch:_____
    Dinner:_____ Snacks:_____
13. Do you crave any foods? YES NO
    If yes, please specify:_____

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, 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?_____
   _____
   _____

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 your 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?_____lbs. DON'T KNOW
2. What would you like to do with your weight? Lose Weight Gain Weight Maintain
3. What was your lowest weight within the past 5 years?_____lbs.
4. What do you consider to be your ideal weight (the sustainable weight at which you feel best)?_____lbs. DON'T KNOW
5. What are your current waist and hip circumferences? Waist_____ Hip_____ DON'T KNOW
6. What is your current body composition? _____%body fat DON'T KNOW

Goals

1. On a scale of 1 to 10, how ready 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?_____
   _____
   _____
5. Please describe any other information you think your health coach should know about regarding your health and fitness and/or health and fitness related goals:
   _____
   _____
   _____

Lifestyle and Health History Questionnaire

_____

_____