Name:_____

DOB:_____ MRN:_____

Age:_____ Date:_____

Lifestyle and Risk Factor

New Visit Questionnaire

Please complete and return to your healthcare provider

Do you have any symptoms or specific issues you'd like to discuss today? Yes □ No □

If yes, please describe:_____

Physical Activity:

Usual activity #1:_____ Sessions per week: _____ Minutes per session: _____

Usual activity #2:_____ Sessions per week: _____ Minutes per session: _____

Other Physical activity: _____

Over the past several years, has your **physical activity level**: Decreased □ Stayed the same □ Increased □

Dietary Practices:

How many servings of **vegetables** do you eat per day? (1 serving =1/2 cup cooked) _____

How many servings of **fruit** do you eat per day? (1 serving = medium apple) _____

How many servings of **whole grains** (brown rice, oatmeal) per day? (1 serving = ½ cup cooked) _____

How many servings (1 serving = ¼ pound) per week of **fish** _____, of **poultry (chicken or turkey)**_____

How many servings of **red meat** per week? (1 serving = ¼ pound) _____

How many **alcoholic drinks** (1 drink = 5 oz wine, 12 oz beer or 1½ oz hard liquor) do you have per week? wine_____ beer_____ hard liquor_____

Weight: Recall your approximate weight at age 20? _____

Over the past several years, has **your weight**: Decreased □ Stayed the same □ Increased □

Smoking: Are you smoking? Yes □ No □ If yes, how many cigarettes per day? _____

Blood Pressure: Do you check your **blood pressure (BP) at home?** Yes □ No □

If yes, what is the typical range? Systolic BP (top #) _____ Diastolic BP (lower #) _____

Cholesterol: Have you ever been told you have high **cholesterol?** Yes □ No □

Have you ever taken medicine for high cholesterol? If so, what?_____

Stress: How would you rate your overall **stress level**? Very low □ Low □ Moderate □ High □ Very high □

Mood: During the past month, have you often been bothered by:

Feeling down, depressed, or hopeless? Yes □ No □

Little interest or pleasure in doing things? Yes □ No □

If female: Have you gone through **menopause**? Yes □ No □ If yes, at what age?_____

Have you had a hysterectomy? Yes □ No □ Have you taken hormone therapy? Yes □ No □

Diabetes: If you have diabetes, please complete the questions on the other side of this page.

Checklist for patients with Diabetes:

Home glucose monitoring: Do you check your **blood sugar** regularly at home? Yes □ No □

If yes, what have your fasting readings been since your last visit?

Highest fasting glucose _____ Lowest fasting glucose _____ Typical fasting glucose _____

American Diabetes Association (ADA) Recommended Annual Examinations:

Have you had the following examinations during the last year?

Eye exam in the last year**?** Yes □ No □ Any problems noted? _____

Dental exam in the last year**?** Yes □ No □ Any problems noted? _____

Foot exam in the last year**?** Yes □ No □ Any problems noted? _____

ADA Recommended Medications: Are you taking the following medications?

If you **don't know, please ask your health care provider**:

Aspirin or similar drugs: Yes □ No □ Don't Know □

Statin (for cholesterol): Yes □ No □ Don't Know □

ACE inhibitor or ARB: Yes □ No □ Don't Know □
(for blood pressure)

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Once you complete this form, please give it to your healthcare provider for review during this appointment.

Revised: 10/8/2010
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