

## Health History Questionnaire

### Part I: General Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First

Occupation: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_ Waist Circumference: \_\_\_\_\_ BMI: \_\_\_\_\_ Body Fat % \_\_\_\_\_

What are your wellness/nutrition goals? (Check all that apply):

- \_\_\_ To feel better overall
- \_\_\_ To improve nutritional habits (e.g., eat fewer sweets, eat more fruits and veggies)
- \_\_\_ To lose weight (If yes, include weight loss goal: \_\_\_\_\_)
- \_\_\_ To lower your blood cholesterol
- \_\_\_ To improve your blood pressure
- \_\_\_ To improve your blood glucose levels
- \_\_\_ To develop better lifestyle skills (e.g., plan & prepare healthful meals and snacks)
- \_\_\_ To reduce stress
- \_\_\_ To improve cardiovascular fitness
- \_\_\_ To improve muscle conditioning
- \_\_\_ Other (please specify) \_\_\_\_\_

### Part II: Medical History

Do you have, or have you ever had, any of the following medical conditions?

- |                                 |   |
|---------------------------------|---|
| ___ Arthritis                   | ___ High Cholesterol                            |
| ___ Diabetes (High Blood Sugar) | ___ High Triglycerides                          |
| ___ Cancer                      | ___ Lung Disease (e.g., asthma, emphysema)      |
| ___ Heart Disease               | ___ Stomach or GI Problems (e.g., peptic ulcer) |
| ___ High Blood Pressure         | ___ Stroke                                      |

Do you have any other medical conditions that may affect your nutritional intake?  
\_\_\_ No \_\_\_ Yes (If yes, please explain: \_\_\_\_\_)

Has anyone in your immediate family (e.g., father, mother, brother, sister) had a heart attack or other heart-related problems before 50 years of age: \_\_\_ No \_\_\_ Yes  
If yes, please explain: \_\_\_\_\_

Please list any medications that you are taking.

Name	Reason

Are you taking a multi-vitamin and/or any other nutritional supplements?

If so what kind? \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? \_\_\_ No \_\_\_ Yes \_\_\_ Cigarettes/day \_\_\_ Cigars/day \_\_\_ Pipes/day

Do you drink alcoholic beverages at all? \_\_\_ No \_\_\_ Yes

- \_\_\_ 0-2 drinks per week
- \_\_\_ 3-6 drinks per week
- \_\_\_ 7-14 drinks per week
- \_\_\_ > 14 drinks per week

Note: One drink equals 1.5 oz. of hard liquor, 4-5 oz. of wine, or 12 oz. beer

Have you had your cholesterol measured within the past year? \_\_\_ No \_\_\_ Yes

If yes: \_\_\_ Total Cholesterol = \_\_\_ above 200 \_\_\_ below 200 \_\_\_ don't know

If yes: \_\_\_ LDL Cholesterol = \_\_\_ above 100 \_\_\_ below 100 \_\_\_ don't know

If yes: \_\_\_ HDL Cholesterol = \_\_\_ above 40 \_\_\_ below 40 (M) \_\_\_ don't know

\_\_\_ above 50 \_\_\_ below 50 (W) \_\_\_ don't know

Which description that best describes the amount & type of stress you experience on a daily basis: \_\_\_ No Stress \_\_\_ Occasional mild stress \_\_\_ Frequent moderate stress

\_\_\_ Frequent high stress \_\_\_ Constant high stress

### *Part III: Weight History*

Have you gained or lost weight in the last 6 months? \_\_\_ No \_\_\_ Yes

If yes, please indicate the amount of weight change to the nearest pound:

\_\_\_ Lost pounds \_\_\_ Gained Pounds

What is your goal weight \_\_\_\_\_. The last time that I weighed my goal weight was

\_\_\_\_\_. What has happened between then & now to cause the weight change?

Have you ever followed a diet to lose weight? \_\_\_ No \_\_\_ Yes (Self or MD prescribed)

If yes, what has been your preferred way of dieting?

\_\_\_ Skip meals

\_\_\_ Reduce portions

\_\_\_ Fasting

\_\_\_ Go on fad diets (e.g., Atkins, Zone)

\_\_\_ Restrict carbohydrates

\_\_\_ Reduce calories

\_\_\_ Restrict fats

\_\_\_ Other (please specify: \_\_\_\_\_)

### *Weight Loss Motivation/Readiness Assessment (If Applicable)*

On a scale of 1-10, with 10 being 100 percent ready, how ready are you to lose weight?

\_\_\_ (1-4 = little intention) \_\_\_ (5-7 = ambivalent) \_\_\_ (8-10 = very willing)

In the past what were your most & least successful attempts to lose weight (if applicable)?

Most successful –

Least successful –

What level of support you can expect from family members and friends?

What barriers to success do you anticipate (time availability, lack of support, etc)?

*Part IV: Diet History*

Are you now, or have you ever been, on any type of special diet? \_\_\_No \_\_\_ Yes

If yes, what type of diet is it: \_\_\_\_\_ (Self or M.D. prescribed)  
(e.g., low calorie, diabetic, low sodium, low fat, low cholesterol, high fiber, vegetarian)

Do you have any problems chewing your food? \_\_\_ No \_\_\_ Yes

List any foods that you do NOT tolerate: \_\_\_\_\_

Do you have any food allergies \_\_\_ No \_\_\_ Yes

If yes, what foods are you are allergic to \_\_\_\_\_

At home, who prepares your meals? \_\_\_\_\_

Do you consume fast food? \_\_\_ No \_\_\_ Yes (no. of times per week) \_\_\_\_\_

If yes, where do you go and what do you currently order off the menu?

Do you eat out at Restaurants? \_\_\_ No \_\_\_ Yes (no. of times per week) \_\_\_\_\_

If yes, where do you go and what do you currently order off of the menu?

## Eating Habits

For each of the statements below, choose the answer that most accurately describes your response based on the scale below:

1) Always      2) Frequently      3) Occasionally      4) Rarely      5) Never

Rate each 1-5:

\_\_\_\_\_ I eat salt-cultured and smoked foods such as ham, bacon, sausage, etc.

\_\_\_\_\_ I eat a variety of foods (e.g., fruits, vegetables, grains, milk or milk products, and meats or meat substitutes).

\_\_\_\_\_ I eat foods high in sodium (e.g. canned soups, deli meats, chips, fast food, frozen dinners)

\_\_\_\_\_ I choose foods low in fat, sugar, and sodium.

\_\_\_\_\_ I eat snacks-- especially after dinner.

\_\_\_\_\_ I add salt to food while cooking and/or after it is served.

\_\_\_\_\_ I bake, broil, or steam food rather than fry.

\_\_\_\_\_ I trim visible fat from meat and remove skin from poultry.

\_\_\_\_\_ I eat three to six consistent meals/snacks a day.

\_\_\_\_\_ When choosing the food I eat, I consider its nutritional value.

What do you feel is the main problem in achieving healthful eating habits?

\_\_\_\_\_ Boredom

\_\_\_\_\_ Stress

\_\_\_\_\_ Late-night eating

\_\_\_\_\_ Binging

\_\_\_\_\_ Eating all day

\_\_\_\_\_ Lack of time

\_\_\_\_\_ Skipping meals

\_\_\_\_\_ Other (please explain)

\_\_\_\_\_

Please provide your typical day's schedule for both a weekday and weekend day.

Please be specific with **name brands** and **amounts** of food.

What time do you wake up                      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

What is the first time that you eat      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Breakfast: \_\_\_\_\_  
\_\_\_\_\_

Do you have a snack before lunch      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

If so, what time is your snack              Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Snack: \_\_\_\_\_  
\_\_\_\_\_

What time is your Lunch                      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Lunch: \_\_\_\_\_  
\_\_\_\_\_

Do you have a snack before dinner      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

If so, what time is you snack              Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Snack: \_\_\_\_\_  
\_\_\_\_\_

What time is your dinner                      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Dinner: \_\_\_\_\_  
\_\_\_\_\_

Do you have a snack after dinner      Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

If so, what time is your snack              Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

Typical Snack: \_\_\_\_\_  
\_\_\_\_\_

What time do you go to sleep              Weekday\_\_\_\_\_      Weekend \_\_\_\_\_

*V. Exercise History*

Do you have any physical problems that cause you to limit your physical activity?

\_\_\_\_ No \_\_\_\_ Yes (please explain) \_\_\_\_\_

Workout Routine: Please provide the time of day you exercise, the type of exercise performed, and how long you exercise. (Please be specific as this will directly affect your meal plan).

Time of Day      Type of Exercise      Number of Minutes

Monday \_\_\_\_\_

\_\_\_\_\_

Tuesday \_\_\_\_\_

\_\_\_\_\_

Wednesday \_\_\_\_\_

\_\_\_\_\_

Thursday \_\_\_\_\_

\_\_\_\_\_

Friday \_\_\_\_\_

\_\_\_\_\_

Saturday \_\_\_\_\_

\_\_\_\_\_

Sunday \_\_\_\_\_

\_\_\_\_\_