



Instructions: Please fill in your responses like this using a No. 2 pencil.

Incorrect Marks X O ✓

Lifestyle Questionnaire

All data collected and processed will be kept strictly confidential.

1. Name: Last, First, M.I. Please Print
2. ID #: optional
3. Age: 10-90
4. Sex: Male, Female

Questions 5 - 10:

How many members of your family have had any of the following before the age of 60?

Include:

grandparents, parents, brothers and sisters.

Do you have or have you been treated for any of the following conditions?

Questions 10 - 15:

- A = No
B = Yes, no treatment
C = Yes, treated before
D = Yes, treated now

5. Heart Disease
6. Stroke
7. High Blood Pressure
8. High Cholesterol
9. Diabetes
10. Cancer
11. Heart Disease
12. Stroke
13. High Blood Pressure
14. High Cholesterol
15. Diabetes
16. Cancer

FOR WOMEN ONLY (men go to question 20)

17. How often do you have a Pap smear?
18. How often do you examine your breasts for lumps?
19. How often does a doctor or nurse examine your breasts for lumps?
20. How often do you have a mammogram? (breast x-ray)

FOR MEN ONLY (women go to question 22)

21. How often do you have a prostate exam and/or a PSA test?
22. How often do you examine your testicles for lumps?

## EXAMINATIONS

- Almost never
- Every few years
- Every year
- Almost never
- Every few years
- Every year

23. How often do you have a thorough physical exam?
24. How often do you have a proctoscopic exam (examination of the colon and rectum)?

## LIFESTYLE BEHAVIORS

- Have never smoked or quit over 15 years ago
- Have quit between 6 and 15 years ago
- Have quit between 2 and 5 years ago
- Have quit less than 2 years ago
- Smoke less than one pack of cigarettes a day
- Smoke more than one pack of cigarettes a day
- Do not dip or chew
- Consume a can or plug every 4 days or more
- Consume a can or plug every 1 to 3 days
- No
- Yes
- Zero
- One to two
- Three to four
- Five or more
- Zero
- One to nine
- Ten to fourteen
- Fifteen or more

25. Do you smoke cigarettes?
26. Do you use smokeless tobacco (dip or chew)?
27. Do you smoke cigars or pipes?
28. How many drinks do you usually drink at one time? (1 drink = 1 beer or 5 oz. of wine or 1 1/2 oz. liquor)
29. Approximately how many alcoholic beverages do you drink in a typical week?

## SAFETY

- Almost never
- About half of the time
- Over 90% of the time
- No
- Yes
- No
- Yes
- No
- Yes

30. How often do you wear a seat belt?
31. Do you ever drive a vehicle soon after (within 2 hours) drinking alcoholic beverages?
32. Do you have a working fire extinguisher(s) in your home?
33. Do you have a working smoke alarm(s) in your home?

## STRESS

- Moved to a new residence
- Married, divorced or separated
- Lost a loved one
- Changed or lost a job
- Had an emotional illness
- Care giver for a dependent person
- Financial stress or loss of income
- Stressful family member in the home
- Excessive work deadlines/overtime

34. What potential stress factors have you experienced in the past year or so?

*Please mark ALL that apply.*

35. Tension/migraine  A  B  C  D  E
36. Insomnia/restless sleep  A  B  C  D  E
37. Nervous stomach  A  B  C  D  E
38. Difficulty breathing  A  B  C  D  E
39. Muscle tension in neck/shoulder/jaw  A  B  C  D  E
40. Lower back pain  A  B  C  D  E
41. Feel depressed/sad  A  B  C  D  E
42. Use counseling  A  B  C  D  E
43. Use mood-changing substances  A  B  C  D  E

Questions 35 - 43:

The conditions to the right often accompany stress. Indicate how often you experience each.

- A = Almost Always**
- B = Frequently**
- C = Occasionally**
- D = Seldom**
- E = Never**

## NUTRITION

Please indicate the number of daily servings you eat of the following types of food:

44. How many servings of protein do you eat daily?  
(For example: 3 3-oz.. serving of beef, pork, poultry, fish;  
1/2 cup of dried beans; 1 egg; 2 tablespoons of peanut butter.)  0  1  2  3  4  5  6+
45. How many servings of vegetables do you eat daily?  
(For example: 1 cup of raw leafy vegetables; 1/2 cup cooked  
vegetables; 3/4 cup of vegetable juice.)  0  1  2  3  4  5  6+
46. How many servings of fruit do you eat daily?  
(For example: 1 small piece of fruit; 1/2 cup chopped fruit;  
3/4 cup of fruit juice.)  0  1  2  3  4  5  6+
47. How many servings of grain and grain products do  
you eat daily?  
(For example: 1/2 cup of cereal, pasta or rice; 1 slice of bread.)  0  1  2  3  4  5  6+
48. Are you able to digest milk and milk products  
without any problem?  No  Yes
49. How many servings of milk and milk products (whole  
or low fat) do you eat and drink daily?  
(For example: 1 cup of milk, yogurt or pudding; 1 1/2 oz.  
of cheese, 2 cups of cottage cheese.)  0  1  2  3  4  5+
50. Do you take dietary supplements that contain calcium?  No  Yes
51. How many servings of foods containing fat and/or  
cholesterol do you eat daily?  
(For example: 3 oz. or more of red meat or organ meat; 2  
tablespoons of gravy; 1 1/2 oz of cheese; 1 tablespoon of  
butter; 1 cup of whole milk, 2 tablespoons of cream;  
1/2 cup of ice cream; 2 tablespoons of mayonnaise.)  0  1  2  3  4  5  6+

## EXERCISE & PHYSICAL ACTIVITY

52. How many days per week do you do flexibility  
exercises such as bending, stretching, and twisting,  
for 10 minutes or more?  0  1  2  3  4  5  6  7
53. How many days per week do you do muscle strength  
and endurance exercises such as calisthenics, free  
weights or heavy lifting.  0  1  2  3  4  5  6  7
54. How many days per week do you walk (or equivalent  
activity) for at least 20 minutes at a time?  0  1  2  3  4  5  6  7
55. How many days per week do you engage in aerobic  
activity - continuous, rhythmic activity - for 30 minutes  
or more at a time?  
(Examples: fast walking; jogging; dancing;  
swimming; bicycling; etc.)  0  1  2  3  4  5  6  7

## BACK CARE

56. Have you experienced discomfort/pain in your back  
that lasted a day or more?  No  Many times  
 A few times
57. During the course of your typical week, how often  
do you sit for extended periods of time or lift heavy  
objects?  Very seldom  Daily  
 Frequently
58. Do you currently do any of the following back care  
measures?  Regular exercise  
 Exercises for the back  
 Good body mechanics/posture while lifting or sitting  
 None of the above

## INFORMATION

When do you feel that you'll be ready to work on improving the following issues?

- 59. Blood Pressure Level       A  B  C  D  E  F
- 60. Cholesterol Level         A  B  C  D  E  F
- 61. Exercise Routine          A  B  C  D  E  F
- 62. Diet and Nutrition         A  B  C  D  E  F
- 63. Weight Control             A  B  C  D  E  F
- 64. Stress/Depression         A  B  C  D  E  F
- 65. Tobacco Use                A  B  C  D  E  F
- 66. Alcohol Use                 A  B  C  D  E  F
- 67. Safety Practices           A  B  C  D  E  F
- 68. Preventive Exams          A  B  C  D  E  F
- 69. Back Care                  A  B  C  D  E  F

- A = Not ready to change**
- B = Not an issue**
- C = Over 6 months from now**
- D = Within 6 months**
- E = Within 30 days**
- F = Now**



## CLINICAL MEASURES

70. Height	
Feet	Inches
	<input type="radio"/> 0
	<input type="radio"/> 1
	<input type="radio"/> 2
	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

71. Weight		
100	200	300
<input type="radio"/> 00	<input type="radio"/> 00	<input type="radio"/> 0
<input type="radio"/> 10	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 20	<input type="radio"/> 20	<input type="radio"/> 2
<input type="radio"/> 30	<input type="radio"/> 30	<input type="radio"/> 3
<input type="radio"/> 40	<input type="radio"/> 40	<input type="radio"/> 4
<input type="radio"/> 50	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

72. Body Fat Percent		
<input type="radio"/> 00	<input type="radio"/> 0	<input type="radio"/> 0.0
<input type="radio"/> 10	<input type="radio"/> 1	<input type="radio"/> 0.1
<input type="radio"/> 20	<input type="radio"/> 2	<input type="radio"/> 0.2
<input type="radio"/> 30	<input type="radio"/> 3	<input type="radio"/> 0.3
<input type="radio"/> 40	<input type="radio"/> 4	<input type="radio"/> 0.4
	<input type="radio"/> 5	<input type="radio"/> 0.5
	<input type="radio"/> 6	<input type="radio"/> 0.6
	<input type="radio"/> 7	<input type="radio"/> 0.7
	<input type="radio"/> 8	<input type="radio"/> 0.8
	<input type="radio"/> 9	<input type="radio"/> 0.9

73. Body Frame Size	
<input type="radio"/> Small	
<input type="radio"/> Medium	
<input type="radio"/> Large	



**Do not complete questions 69 through 76.**

**This section will be filled out by our clinical staff.**

**Thank you.**

74. Blood Pressure		If BP not known, mark range
Systolic (mmHg)	Diastolic (mmHg)	
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
	<input type="radio"/> 30	<input type="radio"/> 3
	<input type="radio"/> 40	<input type="radio"/> 4
	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9
		<input type="radio"/> High
		<input type="radio"/> Low or Normal
		<input type="radio"/> Don't know

75. Triglyceride (mg/dl)		
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
<input type="radio"/> 300	<input type="radio"/> 30	<input type="radio"/> 3
<input type="radio"/> 400	<input type="radio"/> 40	<input type="radio"/> 4
<input type="radio"/> 500	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

76. Cholesterol		
Total (mg/dl)	HDL (mg/dl)	LDL (mg/dl)
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
	<input type="radio"/> 30	<input type="radio"/> 3
	<input type="radio"/> 40	<input type="radio"/> 4
	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

77. Glucose (mg/dl)		
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
	<input type="radio"/> 30	<input type="radio"/> 3
	<input type="radio"/> 40	<input type="radio"/> 4
	<input type="radio"/> 50	<input type="radio"/> 5
	<input type="radio"/> 60	<input type="radio"/> 6
	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9



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