Lifestyle and Health Risk Questionnaire

Your Name:_____ Age:_____ SB6 Sex:_____ SB8 Date:_____

Provider notes: Height (inches): _____ Weight (lbs): _____ BMI: _____ SB5
Waist circumference (inches): _____ Neck circumference (inches): _____ SB7

Physical Activity

On average, how often and how long do you exercise?	days per week: _____ minutes per day: _____
At what intensity (how hard) do you usually exercise? HELP2, PAVS	☐ light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)
What **types** of physical activity do you do? HELP2	List: _____ _____
How often do you do muscle strengthening activities or exercises?	days per week: _____ minutes per day: _____
How many "screen-time" hours do you have each day: TV, video games, sitting at the computer (not counting work and school)? HELP2	screen-time hours per day: _____
How many total hours sitting do you have each day (including at work and school)?	total sitting hours per day: _____
Have you fallen in the past year? If so, how often?	yes ☐ how often? _____ no ☐
Do you feel unsteady when you are walking?	yes ☐ no ☐

Provider notes:

Nutrition

On average, how many days a week do you eat a healthy breakfast? HELP2	days per week: _____
On average, how many 12-ounce servings of sweetened drinks do you have each day? HELP2	servings per day: _____ servings per week: _____
On average, how many servings of fruits and vegetables do you eat each day? HELP2	total servings per day: _____ (fruits:_____/day; veggies:_____/day)
On average, how many uninterrupted meals do you have per week? HELP2	meals per week: _____
On average, how many servings of dairy do you have each day?	servings per day: _____
How often do you eat while doing other things like watching TV?	☐ rarely ☐ occasionally ☐ often
Do you ever eat in secret?	☐ no ☐ yes
On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your nutrition habits and stick to it?	(1–10): _____

Provider notes:

Pat Qst 50113

(Reviewed 01/05/2023) CPM015b - 01/23

Sleep, Mental Health, Social Support

Over the past 2 weeks, how many hours of sleep did you typically get (including naps)? HELP2 — hours per day: _____

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? SB1 — ☐ no ☐ yes

Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep? SB1 — ☐ no ☐ yes

Has anyone ever observed you stop breathing during your sleep? SB3 — ☐ no ☐ yes

In the past 2 weeks, have you been feeling down, depressed, or hopeless? HELP2 — ☐ no ☐ yes

During the past 2 weeks, have you had little interest or pleasure in your usual activities? HELP2 — ☐ no ☐ yes

Who do you most commonly talk to or go to for help when you do not feel well or you are distressed? HELP2

☐ I usually don't talk to anyone ☐ My support is exhausted or burnt out ☐ I talk to a friend, clergyman, church leader, spouse, or partner

Do you have people in your life who negatively affect your efforts to live a healthy lifestyle? ☐ no ☐ yes who? _____

On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your healthy habits related to sleep, stress, or social support? (1–10):_____

Provider notes:

Weight

How concerned are you about the impact of your weight on your health?
☐ very unconcerned ☐ unconcerned ☐ neutral ☐ concerned ☐ very concerned

Would you like to change your weight? ☐ no ☐ yes If yes, how would you like to change your weight? _____

Have you tried to change you weight before? ☐ no ☐ yes If yes, answer these questions:

What methods() did you use? _____

_____

How much did your weight change?_____

How long did you maintain that weight? _____

How much did you gain back?_____ pounds

Do you (or did you ever) take medication or supplements for weight loss? ☐ no ☐ yes
If yes, what did you take: _____

On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to adopt health behaviors that help you maintain a healthy weight? (1–10): _____

Provider notes:

(Reviewed 12/14/2022) CPM015b - 01/23

Other Lifestyle Risk Factors and Conditions

Do you have any of the following health conditions? ☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ type 2 diabetes ☐ obstructive sleep apnea ☐ depression

Do any of your immediate family members have any of the following, and if so, who?
☐ heart disease - who: _____ ☐ diabetes - who: _____
☐ obesity - who: _____ ☐ depression - who: _____

On average, how many drinks of alcohol do you have each day? HELP2 (1 drink = 12-ounce beer, 5-ounce wine, 1.5-ounce liquor)
drinks per day: _____
drinks per week: _____

Do you use tobacco? HELP2 ☐ never ☐ former ☐ current If former or current, answer the questions below:

Date last used: _____ What kind(s)?_____ How much per day? HELP2 _____
How many years? HELP2 _____

List all medications or supplements you take: HELP2

_____

What other concerns do you have about your health or health habits?

_____

Provider notes:

PAVS = PAVS questions
SBx = part of Stop Bang screen
HELP2 = fields in HELP2 preventive tab

Notes