LiVe Well 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 many days per week** do you exercise or do physical activity? HELP2, PAVS	days per week: _____
On average, **how many minutes of physical activity or exercise** do you perform on each of those days? HELP2, PAVS	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: _____
On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your **activity** habits and stick to it?	(1–10): _____

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 **meals per week** do you eat with your family? HELP2	meals per week: _____
On average, how many servings of **dairy** do you have each day?	servings per day: _____
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: _____
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:

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Sleep, Mental Health, Social Support

How many **hours of sleep** do 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

Do you think you are: ☐ underweight ☐ about right ☐ overweight ☐ obese ☐ very obese

Would you like to lose weight? ☐ no ☐ yes If yes, how many pounds would you like to lose? _____

Have you tried to lose weight before? ☐ no ☐ yes If yes, answer the questions below:

What methods did you use? _____

Were you successful? ☐ no ☐ yes How much weight did you lose? _____ pounds

How long did you keep it off? _____ 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 **lose weight and/or maintain weight** you already lost? (1–10):_____

Provider notes:

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: _____

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

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