Lifestyle and Health Risk Questionnaire

Your Name:_____ Age:_____Sex:_____ Date:_____

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

This Visit

List your health concerns today in order of importance (e.g. exercise, nutrition, medical, sleep, stress, pain)

1. _____ 3. _____

2. _____ 4. _____

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? PAVS	☐ Light (casual walk) ☐ Moderate (brisk walk) ☐ Vigorous (jog/run)
What types of physical activity do you do?	
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)?	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 ☐ No How often?_____
Do you feel unsteady when you are walking?	☐ Yes ☐ No

Nutrition

On average, how many days a week do you eat a healthy breakfast?	Days per week: _____
What and how much do you drink each day? (1 cup = 8 oz; 1 can of soda= 12 oz.; 1 plastic water bottle = 16 oz.)	_____oz. caffeinated beverages _____oz. soda _____oz. juice or sweetened drinks _____oz. water
On average, how many servings of fruits and vegetables do you eat each day?	Total servings per day: _____ (fruits:____/day; veggies:____/day)
On average, how many uninterrupted meals do you have per week?	Meals per week: _____
On average, how many servings of dairy do you have each day?	Servings per day: _____
Do you ever eat in secret?	☐ Yes ☐ No

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Nutrition (continued)

How often do you eat while doing other things like watching TV?	☐ Rarely ☐ Occasionally ☐ Often
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): _____

Sleep, Mental Health, and Social Support

Over the past 2 weeks, how many hours of sleep did you typically get (including naps)?	Hours per day: _____
Do you snore loudly ? (louder than talking or loud enough to be heard through closed doors)	☐ Yes ☐ No
Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?	☐ Yes ☐ No
Has anyone ever observed you stop breathing during your sleep?	☐ Yes ☐ No
In the past 2 weeks, have you been feeling down, depressed, or hopeless?	☐ Yes ☐ No
During the past 2 weeks, have you had little interest or pleasure in your usual activities?	☐ Yes ☐ No

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

☐ 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?	☐ Yes ☐ No 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):_____

Weight (Skip this section if you do not want to discuss your 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? ☐ Yes ☐ No

If you are interested in changing your weight, what methods would you like to discuss?

☐ Nutrition ☐ Physical activity ☐ Weight-loss medications ☐ Weight-loss surgery ☐ Diets

Have you tried to change your weight before? ☐ Yes ☐ No If yes, answer the questions below

What methods did you use? _____

How much did you lose? _____ How much have you regained ? _____

Do you or did you ever take medication or supplements for weight loss? ☐ Yes ☐ No

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) _____

Other Lifestyle Risk Factors and Conditions

Do you have any of the following health conditions or past medical history?

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Obstructive sleep apnea
- ☐ Depression
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Chronic pain
- ☐ Arthritis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Substance abuse

Do any of your immediate family members have any of the following? (Leave blank if unknown)

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Obstructive sleep apnea
- ☐ Depression
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Chronic pain
- ☐ Arthritis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Substance abuse

On average, how many drinks of alcohol do you have? (1 drink= 12 oz beer, 5 oz wine, or 1.5 oz liquor)

Drinks per day _____

Drinks per week _____

Do you use tobacco? ☐ Never ☐ Former ☐ Current If former or current answer below

Last time used? _____ What kinds? _____

How much per day? _____ How many years? _____

Do you use e-cigarettes (vape)? ☐ Never ☐ Former ☐ Current If former or current answer below

Last time used? _____ What kinds? _____

How much per day? _____ How many years? _____

Do you use recreational drugs? ☐ Never ☐ Former ☐ Current If former or current answer below

Last time used? _____ What kinds? _____

How much per day? _____ How many years? _____

List all the medications and supplements (e.g vitamins) that you take.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

_____

_____

_____

_____

PAVS- Physical Activity Vital Sign

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