**Lifestyle and Risk Factor**

**New Visit Questionnaire**

Please complete and return to your healthcare provider

**Do you have any symptoms or specific issues you’d like to discuss today?**  Yes □ No □

If yes, please describe: __________________________________________________________

**Physical Activity:**

<table>
<thead>
<tr>
<th>Usual activity #1: __________________________________</th>
<th>Sessions per week: ____</th>
<th>Minutes per session: ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual activity #2: __________________________________</td>
<td>Sessions per week: ____</td>
<td>Minutes per session: ____</td>
</tr>
<tr>
<td>Other Physical activity: ____________________________</td>
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</tbody>
</table>

Over the past several years, has your **physical activity level**: Decreased □ Stayed the same □ Increased □

**Dietary Practices:**

- How many servings of **vegetables** do you eat per day? (1 serving = 1/2 cup cooked) __________
- How many servings of **fruit** do you eat per day? (1 serving = medium apple) __________
- How many servings of **whole grains** (brown rice, oatmeal) per day? (1 serving = 1/2 cup cooked) ______
- How many servings (1 serving = 1/4 pound) per week of **fish** _____, of **poultry (chicken or turkey)** ______
- How many servings of **red meat** per week? (1 serving = 1/4 pound) __________

**Weight:** Recall your approximate weight at age 20? ______

Over the past several years, has your **weight**: Decreased □ Stayed the same □ Increased □

**Smoking:** Are you smoking?  Yes □ No □

If yes, how many cigarettes per day? ______

**Blood Pressure:** Do you check your **blood pressure (BP) at home**? Yes □ No □

If yes, what is the typical range? Systolic BP (top #) ________ Diastolic BP (lower #) ________

**Cholesterol:** Have you ever been told you have high **cholesterol**? Yes □ No □

Have you ever taken medicine for high cholesterol? If so, what?____________________________________

**Stress:** How would you rate your overall **stress level**? Very low □ Low □ Moderate □ High □ Very high □

**Mood:** During the past month, have you often been bothered by:

- Feeling down, depressed, or hopeless? Yes □ No □
- Little interest or pleasure in doing things? Yes □ No □

**If female:** Have you gone through **menopause**? Yes □ No □

If yes, at what age? ______

Have you had a hysterectomy?  Yes □ No □

Have you taken hormone therapy? Yes □ No □

**Diabetes:** If you have diabetes, please complete the questions on the other side of this page.
Checklist for patients with Diabetes:

**Home glucose monitoring:** Do you check your **blood sugar** regularly at home? Yes □ No □

If yes, what have your fasting readings been since your last visit?

Highest fasting glucose _______  Lowest fasting glucose _______  Typical fasting glucose _______

**American Diabetes Association (ADA) Recommended Annual Examinations:**

Have you had the following examinations during the last year?

- **Eye exam** in the last year? Yes □ No □ Any problems noted? ___________________________

- **Dental exam** in the last year? Yes □ No □ Any problems noted? ___________________________

- **Foot exam** in the last year? Yes □ No □ Any problems noted? ___________________________

**ADA Recommended Medications:** Are you taking the following medications?

If you **don’t know, please ask your health care provider:**

- **Aspirin** or similar drugs: Yes □ No □ Don’t Know □

- **Statin** (for cholesterol): Yes □ No □ Don’t Know □

- **ACE inhibitor or ARB** (for blood pressure) Yes □ No □ Don’t Know □

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Once you complete this form, please give it to your healthcare provider for review during this appointment.