Lifestyle and Risk Factor
Return 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:
Usual activity #1:______________________   Sessions per week: _____      Minutes per session: _____
Usual activity #2:______________________   Sessions per week: _____      Minutes per session: _____
Other Physical activity: _________________________________________________________________

Since you last visit has your overall physical activity level: Decreased □ Stayed the same □ Increased □

Dietary Practices:
How many servings of vegetables are you eating per day? (1 serving = ½ cup cooked) _____________
How many servings of fruit are you eating per day? (1 serving = medium apple) _______________
How many servings of whole grains (brown rice, oatmeal) per day? (1 serving = ½ cup cooked) _____
How many servings (1 serving = ¼ pound) per week of fish _____, of poultry (chicken or turkey)_____ 
How many servings of red meat per week? (1 serving = ¼ pound) ___________
How many alcoholic drinks (1 drink = 5 oz wine, 12 oz beer or 1½ oz liquor) do you have per week?_____ 
Since your last visit, is your eating pattern: Better □ No different □ Worse □

If different, in what ways? _____________________________________________________________

Weight: Since your last visit, has your weight: Decreased □ Stayed the same □ Increased □

If changed, what accounts for this? ______________________________________________________

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 #) ____________

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 □

Medications: Have your medications changed since your last visit?   Yes □ No □

If yes, what has changed:______________________________________________________________

Are you having side effects from your medications? If yes, describe:_____________________________

Diabetes: If you have diabetes, please complete the questions on the other side of this page.

Once you complete this form, please give to your healthcare provider for review during this appointment.
**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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Revised: 10/08/2010