AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH

Produced in collaboration with Loma Linda University

Lifestyle Assessment Long Form

GETTING STARTED

		Very poor health										Excellent health
a.	Please circle your current overall **LEVEL OF HEALTH**.	0	1	2	3	4	5	6	7	8	9	10

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

Sleep _____ Weight Management _____ Nutrition _____

Exercise _____ Purpose & Connection _____ Mental Health _____

Substance Use _____

		Not important at all										Very important
c.	How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
d.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
e.	How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
f.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
g.	How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
h.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

☐ More medical/scientific knowledge ☐ Practical health tips ☐ Other: _____

☐ Accountability ☐ Personalized plan

Patient Name:_____ DOB: _____

SLEEP

Please answer based on your sleeping patterns OVER the LAST TWO WEEKS	Never	Seldom	Sometimes	Often	Always
a. How often have you had difficulty staying awake during routine tasks?	1	2	3	4	5
b. How often have you had difficulty staying awake while driving?	1	2	3	4	5
c. How often have you felt fatigued or needed to nap during the day?	1	2	3	4	5
d. How often has it taken you more than 30 minutes to fall asleep at night?	1	2	3	4	5
e. How often have you woken up at night?	1	2	3	4	5
f. How often have you unintentionally woken up early in the morning?	1	2	3	4	5
g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?	1	2	3	4	5
h. How often have your legs or arms jerked during sleep?	1	2	3	4	5
i. How often have you experienced “creeping” or “crawling” feelings in your legs?	1	2	3	4	5
j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep?	1	2	3	4	5
k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep?	1	2	3	4	5
l. Do you have a job that requires night shifts?	1	2	3	4	5
m. Do you have a medical condition or chronic pain that interferes with your sleep?	1	2	3	4	5
n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5
o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5

Patient Name:_____ DOB: _____

NUTRITION

EATING PATTERNS

Please answer based on your typical eating habits

a. On average, how many cups (8 oz.) of caffeinated beverages do you drink **per day** (tea, soda, coffee, or energy drinks)? 0 1 2 3 4+

b. On average, how many servings of alcohol do you drink **per day**? 0 1 2 3 4+

c. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you drink **per day**? 0 1 2 3 4+

d. On average, how often do you snack on convenience or "junk" food **per day**? (i.e. chips, candy, granola bars, crackers, cookies, etc.) 0 1 2 3 4+

e. On average, how many meals do you buy from a restaurant or fast food **per week**? 0 1 2 3 4+

f. On average, do you drink at least 8 glasses of water **per day**? No Yes

g. On average, do you eat at least 5 handfuls of nuts **per week**? No Yes

h. Do you use natural or artificial sweeteners? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.) No Yes

i. Do you add salt to most of your meals? No Yes

j. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)? No Yes

k. Do you have any bad reactions (sensitivities or allergies) to food? If yes, please list here: _____

l. Do you avoid any particular foods? If yes, please list here: _____

m. Do you have foods that you crave? If yes, please list here: _____

n. Are you currently following a particular diet or nutrition plan? If yes, please list here: _____

o. During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here: _____

p. Are you concerned about making the wrong food choices? If yes, please explain here: _____

q. Have you ever had an eating disorder? If yes, please list here: _____

Do you use any of the following VITAMINS or SUPPLEMENTS? ***Check all that apply***

❑ Vitamin D ❑ Calcium ❑ Vitamin B12
❑ Probiotics ❑ Omega 3 ❑ Multivitamin
Other: _____

Do you use any of the following OILS with your meals or cooking? ***Check all that apply***

❑ Olive Oil ❑ Canola Oil ❑ Vegetable Oil
❑ Coconut Oil ❑ Butter ❑ Lard
Other: _____

FOOD RECALL: ***Please record below what AND how much you ate and drank yesterday (or the last typical day)***

Breakfast: _____ Time: _____

Lunch: _____ Time: _____

Dinner: _____ Time: _____

Snacks: _____ Time: _____

Drinks/Beverages: _____ Time: _____

Patient Name:_____ DOB: _____

WEIGHT MANAGEMENT

BEHAVIOR PATTERNS	Never	Seldom	Sometimes	Often	Always
a. How often do you skip meals?	1	2	3	4	5
b. How often do you snack in between meals?	1	2	3	4	5
c. How often do you eat while watching TV?	1	2	3	4	5
d. How often do you eat while in bed?	1	2	3	4	5
e. How often do you have difficulty sleeping?	1	2	3	4	5
f. How often do you lack physical activity or exercise?	1	2	3	4	5
g. How often do you feel a lack of purpose or meaning in your life?	1	2	3	4	5

Which of the following factors apply to your eating habits and current lifestyle? ***Check all that apply***

❑ Like healthy food	❑ Don't like healthy food	❑ Know how to cook healthy foods
❑ Fast eater	❑ Eat slowly	❑ Read nutrition labels
❑ Rely on packaged or fast foods	❑ Dislike cooking	❑ Prepare meals at home
❑ Do not plan meals	❑ Eat a variety of foods	❑ Always hungry
❑ Late night eater	❑ Negative relationship to food	❑ Erratic eater
❑ No time to prepare healthy food choices	❑ Don't know how to cook	❑ Live alone or eat alone often

Do any of the following situations or emotions cause you to eat? ***Check all that apply***

❑ Sadness	❑ Pain	❑ Insomnia	❑ Anxiety
❑ Fatigue	❑ Social or Family Situations	❑ Boredom	❑ Stress

Patient Name:_____ DOB: _____

WEIGHT MANAGEMENT (continued)

WEIGHT HISTORY

a.	Have you ever been overweight or obese? If yes, answer below:	No	Yes
	Were you overweight as a child?	No	Yes
	Were you overweight as a teenager?	No	Yes
	Were you overweight between the ages of 20-29?	No	Yes
	Were you overweight between the ages of 30-39?	No	Yes
	Were you overweight above the age of 40?	No	Yes
b.	Are you currently trying to lose or gain weight?	No	Yes
	If yes, please circle your goal: Lose weight Gain weight		
c.	Have you ever intentionally lost or reduced your weight by more than 5 lbs.?	No	Yes
	If yes, did you regain weight within 1 year?	No	Yes
d.	Have you had weight loss surgery?	No	Yes

If yes, please list the type of surgery you had: _____

Have you ever used weight loss medications? ***If yes, circle which ones you have used? If other, please list.***

❑ Acutrim	❑ Alli	❑ Amphetamines	❑ Anorex	❑ Belviq	❑ Byetta	❑ Contrave
❑ Dexatrim	❑ Didrex	❑ Fastin	❑ Fenfluramine	❑ Mazanor	❑ Meridia	❑ Obalan
❑ Phendiet	❑ Fen-Phen	❑ Phentermine	❑ Plegine	❑ Plegine	❑ Prozac	❑ Pondimin
❑ Qsymia	❑ Redux	❑ Sanorex	❑ Tenuate	❑ Tepanol	❑ Vyvanse	❑ Wechless
❑ Wellbutrin	❑ Xenical	❑ I don't remember the name of the medication				

❑ Other _____

WEIGHT LOSS STATEGIES

Have you tried any of the following alternative therapies or programs? ***Check all that apply. If other, please list.***

❑ Acupuncture	❑ Acupressure	❑ Nutritionist/Registered Dietitian
❑ Residential Programs	❑ Hypnosis	❑ Physical Activity/Exercises

❑ Other _____

Which commercial or fad diets have you tried in the past? ***Check all that apply. If other, please list.***

❑ Atkins Diet	❑ Low Fat	❑ Calorie Counting	❑ Paleo
❑ CHIP	❑ South Beach	❑ DASH	❑ Vegan
❑ Mediterranean Diet	❑ Elimination Diet (Allergy)	❑ Gluten Free	❑ Vegetarian
❑ Jenny Craig	❑ Weight Watchers	❑ Low Carb	❑ Slim Fast/Meal Replacement

❑ Other _____

Patient Name:_____ DOB: _____

EXERCISE

EXERCISE HABITS: AEROBIC/CARDIO TRAINING

a. During the average week, how many **days** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough to break a light sweat)? _____days

b. During an average session, how many **minutes** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough movement to break a light sweat)? _____min

_____ total min/week (days x min)

c. List types of aerobic activities you do (i.e. walking, jogging, swimming, bicycling, dancing, etc.): _____

_____

EXERCISE HABITS: STRENGTH/RESISTANCE TRAINING

a. During the average week, how many **days** do you do strength/resistance training? _____days

b. How many **minutes** do you exercise with strength/resistance training? _____min

_____ total min/week (days x min)

c. List types of activities you do (i.e. weightlifting, Pilates, kettle ball, resistance machines, exercise bands, etc.):____

_____

What MOTIVATES you *or would motivate you* to exercise? *Check top three*

- ❑ Nothing would motivate me
- ❑ Control Blood glucose
- ❑ Decrease stress
- ❑ Increase self-esteem
- ❑ Family or partner
- ❑ Body Image
- ❑ Prevent heart disease
- ❑ Other:_____
- ❑ Improve mood
- ❑ Increase Energy
- ❑ Prevent Bone loss
- ❑ Weight reduction
- ❑ Reduce blood pressure
- ❑ Improve sleep

Are there any BARRIERS or PROBLEMS that limit exercise? *Check all that apply*

- ❑ No barriers
- ❑ Life Transition Period
- ❑ Family Responsibility
- ❑ Depression
- ❑ Time
- ❑ Apparel
- ❑ Work Responsibility
- ❑ Fear
- ❑ Energy
- ❑ Cost
- ❑ Other

EXERCISE SAFETY

a. Do you have any injuries that would make it difficult to exercise? No Yes
If yes, please explain: _____

b. Do you have any joint, muscle, or bone problems that might get worse with exercise? No Yes
If yes, please explain: _____

c. Do you have any breathing problems while exercising? No Yes
If yes, please explain: _____

d. Do you have any balance problems or have had a fall in the last 6 months? No Yes
If yes, please explain: _____

e. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)? No Yes
If yes, please explain: _____

Do you have any of the following health problems? ***Check all that apply***

- ❑ Arrhythmia or irregular heartbeat
- ❑ Arthritis or significant joint pain
- ❑ Chest pain/angina
- ❑ Uncontrolled diabetes
- ❑ Severe or uncontrolled heart failure
- ❑ Uncontrolled asthma
- ❑ Recent heart attack
- ❑ Chronic or unusual fatigue/tiredness
- ❑ Difficulty breathing with activity
- ❑ Other

MENTAL HEALTH

PERCEIVED STRESS	Never	Seldom	Sometimes	Often	Always
a. How often have you felt that you were unable to control the important things in your life?	1	2	3	4	5
b. How often have you felt **lack of** confidence about your ability to handle your personal problems?	1	2	3	4	5
c. How often have you felt that things were **not** going your way?	1	2	3	4	5
d. Have often have you found it hard to let go of things that upset you?	1	2	3	4	5

How do you COPE with stress? ***Check all that apply***

❑ Meditation	❑ Food (too much, too little)	❑ Gambling	❑ Distraction
❑ Exercise/Physical Activity	❑ Spirituality/Faith	❑ Journaling	❑ Hurting yourself (i.e. cutting, etc.)
❑ Counseling/Psychotherapy	❑ Sex	❑ Massage/Body work	❑ Pet therapy
❑ Socializing with friends or family	❑ Recreational drugs (i.e. marijuana, cocaine, etc.)	❑ Prayer	❑ Other
❑ Art	❑ Television and/or video games	❑ Substance (tobacco, alcohol)	

RESILIENCE

When I am under extreme stress	Never	Seldom	Sometimes	Often	Always
a. I find a way to learn from my experience.	1	2	3	4	5
b. I find a way to take action.	1	2	3	4	5
c. I find it easy to prioritize what is important in my life.	1	2	3	4	5
d. I look at a stressful situation as an opportunity to grow.	1	2	3	4	5
e. I meet the goals I set for myself.	1	2	3	4	5
f. I believe that there are a lot of ways around a problem.	1	2	3	4	5
g. I feel motivated to pursue my goals.	1	2	3	4	5
h. I know I can get through it.	1	2	3	4	5

Patient Name:_____ DOB: _____

MENTAL HEALTH (continued)

MIND-BODY CONNECTION	Never	Seldom	Sometimes	Often	Always
a. I meet the goals I set for myself.	1	2	3	4	5
b. Do thoughts or feelings affect your physical health?	1	2	3	4	5
c. Could you be experiencing some emotion and not be aware of it?	1	2	3	4	5
d. Are you aware of tension in your body?	1	2	3	4	5
e. Do you notice how your body changes when angry?	1	2	3	4	5
f. Do you notice stress in your body?	1	2	3	4	5
g. Do you notice how your body reacts to emotions?	1	2	3	4	5

DEPRESSION

Over the last 2 weeks, how often have you been bothered by the following?	Not at all	Several days	Most days	Daily
a. Little interest or pleasure in doing things.	0	1	2	3
b. Feeling down, depressed or hopeless.	0	1	2	3
c. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
d. Feeling tired or having little energy.	0	1	2	3
e. Poor appetite or overeating.	0	1	2	3
f. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ANXIETY

Over the last 2 weeks, how often have you been bothered by the following?	Not at all	Several days	Most days	Daily
a. Feeling nervous, anxious, or on edge.	0	1	2	3
b. Not being able to stop or control worrying.	0	1	2	3
c. Worrying too much about different things.	0	1	2	3
d. Trouble relaxing.	0	1	2	3
e. Being so restless that it's hard to sit still.	0	1	2	3
f. Becoming easily annoyed or irritable.	0	1	2	3

Patient Name:_____ DOB: _____

PURPOSE AND CONNECTION

How often do you agree with the following:	Never	Seldom	Sometimes	Often	Always
a. I live a purposeful and meaningful life	1	2	3	4	5
b. I have a spiritual community that I can turn to in times of need	1	2	3	4	5
c. I have a source of inner strength and meaning	1	2	3	4	5
d. I am satisfied with my current belief system	1	2	3	4	5
e. I have people who care about what happens to me	1	2	3	4	5
f. I have people who accept me at my worst and best	1	2	3	4	5
g. I have people I trust at home or work who I can talk to about my problems	1	2	3	4	5
h. I get help when I'm sick	1	2	3	4	5

SMOKING AND SUBSTANCE HISTORY

NICOTINE/TOBACCO (i.e. cigarettes, e-cigarettes, e-cigarettes/vaping, cigars, chew, snuff)

a. Do you use any of the nicotine products listed above? No Yes

If yes, do you want to quit using the nicotine/tobacco products? No Yes

If yes, answer the questions below:

b. How soon after you wake up do you use nicotine/tobacco?

❑ After 60 minutes ❑ 31-60 minutes ❑ 6-30 minutes ❑ Within 5 minutes

c. How many cigarettes do you smoke per day?

❑ 10 or less ❑ 11-20 ❑ 21-30 ❑ 31+

d. What age did you start smoking? _____

e. What is the longest time period you have stayed quit?

_____

f. What made you start smoking again? _____

_____

g. Which of the following people smoke around you?
Check all that apply

❑ Friends ❑ Family ❑ Partner

❑ Co-Workers ❑ Other: _____

h. How many times have you seriously tried to quit? ___

i. For your most recent quit attempt, how long did it last?

_____

j. Who is supporting you to quit smoking? _____

_____

k. What is your most important reason to quit smoking?

_____

_____

_____

_____

l. Are you currently using or have used any medications to help you quit smoking? No Yes

If yes, check with of the following medications you have used:

❑ Nicotine Patch ❑ Nicotine Gum ❑ Nicotine Lozenge

❑ Wellbutrin/Bupropion Pill ❑ Chantix/ Varenicline Pill ❑ Other: _____

m. If you used any of the medication listed above, did they help? No Yes

If yes, list which ones helped: _____

Patient Name:_____ DOB: _____

SMOKING AND SUBSTANCE (continued)

n. Have you used any methods in the past other than medications to try to quit? No Yes

If yes, check which of the following methods you have used:

❑ Self-help ❑ Gradual reduction ❑ Cold turkey ❑ Hypnosis

❑ Acupuncture ❑ Special filters ❑ Vaping/e-cigarettes ❑ Other: _____

ALCOHOL

a. Do you drink alcohol? No Yes

If yes, please answer the questions below:

b. What type of alcohol do you prefer? _____

c. On average, how many servings do you drink per day/week/month/year on average? _____

If yes, please answer the questions below:

d. Have you ever felt you should "**Cut** down" on your drinking? No Yes

e. Have people **Annoyed** you by criticizing your drinking? No Yes

f. Have you ever felt **Guilty** about your drinking? No Yes

g. Have you ever had a drink in the morning to steady your nerves or to get rid of a handover (**eye opener**)? No Yes

h. Do you binge drink (more than 5 drinks for men or 4 drinks for women within 2 hours)? No Yes

Have you used any of the following substances in the past year?

Recreational drugs (cocaine, heroin, meth, etc.) No Yes

If yes, what level of concern do you have regarding use of the substances

No Concern					**High Concern**
0	1	2	3	4	5

If yes, how much substance do you usually use? _____

Marijuana No Yes

If yes, what level of concern do you have regarding use of the substances

No Concern					**High Concern**
0	1	2	3	4	5

If yes, how much substance do you usually use? _____

TREATMENT HISTORY

Have you ever received treatment for a mental health problem? No Yes

Have you ever received treatment for drug or alcohol use? No Yes

Patient Name:_____ DOB: _____

MEDICAL SYMPTOM QUESTIONNAIRE (MSQ)

This questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the **PAST 30 DAYS**. If you are taking after the first time, record your symptoms for the LAST 48 HOURS ONLY.

Point Scale

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE					
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated feeling	0	1	2	3	4
Belching, passing gas	0	1	2	3	4
Heartburn	0	1	2	3	4
Intestinal/stomach pain	0	1	2	3	4
Nausea or vomiting	0	1	2	3	4
Total points_____					
EARS					
Itchy ears	0	0	1	2	3
Earaches, ear infections	0	1	2	3	4
Drainage from ear	0	1	2	3	4
Ringing in ears, hearing loss	0	1	2	3	4
Total points_____					
HEAD					
Headaches	0	1	2	3	4
Faintness or lightheadedness	0	1	2	3	4
Dizziness	0	1	2	3	4
Insomnia	0	1	2	3	4
Total points_____					
HEART					
Irregular or skipped heartbeat	0	1	2	3	4
Chest pain	0	1	2	3	4
Rapid or pounding heartbeat	0	1	2	3	4
Total points_____					
JOINTS/MUSCLES					
Pains or aches in joints	0	1	2	3	4
Arthritis	0	1	2	3	4
Stiffness or limitations of movement	0	1	2	3	4
Pain or aches in muscles	0	1	2	3	4
Feeling of weakness or tiredness	0	1	2	3	4
Total points_____					
LUNGS					
Chest congestion	0	1	2	3	4
Asthma, bronchitis	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Difficulty breathing	0	1	2	3	4
Total points_____					
MIND					
Poor memory	0	1	2	3	4
Confusion, poor comprehension	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor physical coordination	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Stuttering or stammering	0	1	2	3	4
Learning disabilities	0	1	2	3	4
Slurred speech	0	1	2	3	4
Total points_____					

EMOTIONS					
Mood swings	0	1	2	3	4
Anxiety, fear, nervousness	0	1	2	3	4
Anger, irritability, aggressiveness	0	1	2	3	4
Depression	0	1	2	3	4
Total points_____					
ENERGY/ACTIVITY					
Fatigue, sluggishness	0	1	2	3	4
Apathy, lethargy	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Restlessness	0	1	2	3	4
Total points_____					
EYES					
Watery or itchy eyes	0	1	2	3	4
Swollen, reddened or sticky eyelids	0	1	2	3	4
Bags or dark circles under eyes	0	1	2	3	4
Blurred or tunnel vision *(does not include near or far sightedness)*	0	1	2	3	4
Total points_____					
NOSE					
Stuffy nose	0	1	2	3	4
Sinus problems	0	1	2	3	4
Sneezing attacks	0	1	2	3	4
Excessive mucous formation	0	1	2	3	4
Hay fever	0	1	2	3	4
Total points_____					
SKIN					
Acne	0	1	2	3	4
Hives, rashes, dry skin	0	1	2	3	4
Hair loss	0	1	2	3	4
Flushing or hot flushes	0	1	2	3	4
Excessive sweating	0	1	2	3	4
Total points_____					
WEIGHT					
Binge eating/drinking	0	1	2	3	4
Craving certain foods	0	1	2	3	4
Excessive weight	0	1	2	3	4
Water retention	0	1	2	3	4
Underweight	0	1	2	3	4
Compulsive eating	0	1	2	3	4
Total points_____					
OTHER					
Frequent illness	0	1	2	3	4
Frequent or urgent urination	0	1	2	3	4
Genital itch or discharge	0	1	2	3	4
Total points_____					
GRAND TOTAL _____					

KEY: Add individual scores and total each group. Add each group score to give a grand total.
*Optimal is <10; Mild Symptoms: 10-50; Moderate Symptoms: 50-100; Severe Symptoms: over 100

Patient Name:_____ DOB: _____

PREVENTIVE SERVICES

a. Have you had a physical exam and/or "Wellness" Visit in the past 12 months? No Yes I don't know
If yes, list date and outcome: _____

b. Have you had a dental exam and teeth cleaning in the past 12 months? No Yes I don't know
If yes, list date and outcome: _____

c. Have you been screened for diabetes with blood work? No Yes I don't know
If yes, list date and outcome: _____

d. Have you had your cholesterol, lipids or triglycerides measured? No Yes I don't know
If yes, list date and outcome: _____

e. Have you ever had a bone density test to check for osteoporosis? No Yes I don't know
If yes, list date and outcome: _____

f. Do you have any balance problems or have had a fall in the last 6 months? No Yes I don't know
If yes, list date and outcome: _____

g. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)? No Yes I don't know
If yes, list date and outcome: _____

h. Do you have any concerns about your ability to drive safely or have you had any car accidents in the past 12 months? No Yes I don't know
If yes, list date and outcome: _____

i. Do you have any concerns about your memory? No Yes I don't know
If yes, list date and outcome: _____

j. Do you have any trouble with your hearing? No Yes I don't know
If yes, list date and outcome: _____

k. Have you had your eyes checked for vision problems? No Yes I don't know
If yes, list date and outcome: _____

l. Have you ever had your metabolism or thyroid checked? No Yes I don't know
If yes, list date and outcome: _____

m. Have you ever been told that you have a sexually transmitted disease/infection? No Yes I don't know
If yes, list date and outcome: _____

n. If you smoke, have you ever had an abdominal ultrasound to check for possible aneurysms? No Yes I don't know
If yes, list date and outcome: _____

o. Have you ever received counseling behavioral therapy for any of the following problems?

❑ Weight management or obesity ❑ Nutrition ❑ Smoking or use of other nicotine products ❑ Alcohol use

p. Which of the following screenings have you completed

❑ Colon cancer screen (stool test or colonoscopy ❑ Breast cancer screen (mammogram) ❑ Cervical cancer screen (PAP smear)

❑ HIV/AIDS blood work screen ❑ Hepatitis C blood work screen ❑ Depression or sadness screen

q. Have you had the following vaccines?

❑ Flu ❑ Hepatitis B ❑ Pneumococcal or Pneumonia

Patient Name:_____ DOB: _____