HEALTHY LIVING QUESTIONNAIRE
NORTHEAST FAMILY YMCA

Name: ______________________________________ Date: ___________________________

Age: _____ Phone: ___________________________ Email: ___________________________

Occupation: ___________________________________ Work/School Hours: _______________

Please list other people in your household and their relationships to you: _________________________

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GENERAL HEALTH INFORMATION

Physician's name: ______________________________ Physician's Phone: _________________

Physician's address: ____

Date of most recent exam: _______________________ Date of recent blood tests: __________

How do you rate your health? (Please circle) Poor Fair Good Excellent

Height: _____________ Weight: ______________

How often do you use tobacco? ________________ How often do you use alcohol? _____________

How many hours of sleep do you average per night? __________ Is your sleep restful? Yes No

On a scale from 1 (low) to 5 (high), how would you rate your daily stress level? 1 2 3 4 5

How do you cope with stress in your daily life? ____

____

Please list any religious practices that affect your health care or diet: _____________________________

____

List all prescription and over-the-counter medications that you currently take (include the dosages): ___

____

____

List all vitamins, minerals, supplements, and herbs that you take: _______________________________

____

On a scale of 1 (not ready) to 5 (ready), how ready are you to make lifestyle changes? 1 2 3 4 5

On a scale of 1 (not confident) to 5 (confident), how confident are you to make lifestyle changes? 1 2 3 4 5

What makes it hard for you to lose weight and keep it off? ____________________________________

____

____

REVIEW OF SYSTEMS (*CIRCLE ALL THAT YOU CURRENTLY HAVE OR ARE CONCERNED ABOUT*)

RESPIRATORY
Shortness of breath
Coughing
Asthma or Wheezing
Emphysema
Snoring
Daytime Sleepiness
Disturbed Sleep
Sleep Apnea
History of Pneumonia
Chronic Bronchitis
COPD

GASTROINTESTINAL
Nausea/Vomiting
Abdominal/Stomach pain
Heartburn/Acid Reflex
Ulcer Disease
Belching/Burping
Rectal Bleeding
Hemorrhoids
Constipation/Diarrhea
Gallbladder Disease/Gallstones
Celiac Disease/Gluten Intolerance
Hernia

CARDIOVASCULAR
High blood Pressure
Heart disease/Heart attack
Congestive Heart Failure
Heart Murmur
Irregular Heartbeat or Palpitations
Chest pain or Discomfort
Ankle or Feet Swelling
Varicose Veins
Blood Clots or Clotting Disorders

GENITOURINARY
Difficulty Urinating
Urinary Incontinence
Inability to Empty Bladder Fully
Recurrent Urinary Tract Infection
Infertility
Abnormal Menstrual Periods
Enlarged Prostate

MUSCULOSKELETAL
Aching Muscles/Joints
Lower Back Pain/Disc Problems
Arthritis

SKIN & HAIR
Skin Sores/Infections
Bruises Easily
Chronic Rashes/Dermatitis/Eczema

ENDOCRINE
Diabetes Mellitus
High Cholesterol
High Triglycerides
Thyroid Disease
Gout

OTHER
Low Energy Level
Bipolar Disorder
Attention Deficit Disorder (ADD)
Hyperactivity Disorder (ADHD)
Depression
Anxiety Disorder or Panic Attacks
Binge Eating
Obsessive-Compulsive Disorder (OCD)
Anorexia
Anemia
Bulimia
Headaches or Migraines

Other serious medical conditions (list types): ____

____

Do you have a family history of any of the following? (Circle all that apply)

High Blood Pressure High Cholesterol Diabetes Obesity
Heart Disease Cancer Thyroid Disease
Other (list): ____

____

List the types of surgeries you have had: ____

____

NUTRITIONAL INFORMATION

What one or two things would you like to change about your diet? ___________________________

____

In the following chart, describe when and what you usually eat in a typical day.
(Write "None" if you do not eat that meal or snack)

Meal Time Foods Eaten/Amount
Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:

PHYSICAL ACTIVITY INFORMATION

What is the most physically active thing you do in an average day? __________________________

____

What, if any, regular exercises do you do? How often and for how long do you participate? __________

____

Do you know of any reason (s) why you should not do physical activity? Yes No

If yes, please explain the reasons: ____

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