Grand Valley Primary Care Community HOSPITAL

Lifestyle Medicine Program

Name: _____ DOB: _____

Address: _____ Gender: _____

Phone: _____ Email: _____ Best form of contact: **phone/email**

Can we leave a message: **yes/no** Best time of day to be contacted: _____

Height (inches): _____ Weight (lbs): _____ Primary Care Provider (PCP): _____

Physical Activity

On average, **how many days per week** do you exercise or do physical activity?	days per week: _____
On average, **how many minutes of physical activity or exercise** do you perform on each of those days?	minutes per day: _____
At what intensity (how hard) do you usually exercise?	☐ light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)
What types of physical activity do you do? List:	
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: _____
On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your **activity** habits and stick to it?	(1–10): _____

Provider notes:

Nutrition

On average, how many days a week do you eat a healthy **breakfast**?	days per week: _____
On average, how many 12-ounce servings of **sweetened drinks** do you have each **day**?	servings per day: _____ servings per week: _____
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 **meals per week** do you eat with your family?	meals per week: _____
On average, how many servings of **dairy** do you have each day?	servings per day: _____
On average, how many drinks of **alcohol** do you have each **day**? (1 drink = 12-ounce beer, 5-ounce wine, 1.5-ounce liquor)	drinks per day: _____ drinks per week: _____
How often do you eat while doing other things like watching TV?	☐ rarely ☐ occasionally ☐ often
Do you have concerns about your eating habits?	☐ no ☐ yes
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): _____
On average, how many **meals per week** do you eat out?	meals per week: _____

Provider notes:

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Sleep, Mental Health, Social Support

How many **hours of sleep** do you typically get (including naps)? hours per day: _____

Do you **snore** loudly (louder than talking or loud enough to be heard through closed doors)? ☐ no ☐ yes

Do you often feel **tired,** fatigued, or sleepy during the daytime, even after a "good" night's sleep? ☐ no ☐ yes

Has anyone ever **observed** you stop breathing during your sleep? ☐ no ☐ yes

In the past 2 weeks, have you been feeling down, depressed, or hopeless? ☐ no ☐ yes

During the past 2 weeks, have you had little interest or pleasure in your usual activities? ☐ no ☐ yes

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? ☐ no ☐ yes 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):_____

Provider notes:

Weight

Do you think you are: ☐ underweight ☐ about right ☐ overweight ☐ obese ☐ very obese

Would you like to lose weight? ☐ no ☐ yes If yes, how many pounds would you like to lose? _____

Have you tried to lose weight before? ☐ no ☐ yes If yes, answer the questions below:

What methods did you use? _____

Were you successful? ☐ no ☐ yes How much weight did you lose? _____ pounds

How long did you keep it off? _____ How much did you gain back? _____ pounds

Do you (or did you ever) take medication or supplements for weight loss? ☐ no ☐ yes

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 **lose weight and/or maintain weight**? (1–10):_____

Provider notes:

Other Lifestyle Risk Factors and Conditions

Do you currently have, or have a history of any of the following health conditons? ☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ type 2 diabetes ☐ obstructive sleep apnea ☐ depression ☐ orthopedic condition

Do any of your **immediate family members** have any of the following, and if so, who?

☐ heart disease - who: _____ ☐ diabetes - who: _____

☐ obesity - who: _____ ☐ depression - who: _____

Do you use **tobacco**? ☐ never ☐ former ☐ current If former or current, answer the questions below:

Date last used: _____ What kind(s)?_____ How much per day? _____ How many years? _____

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

Provider notes:

Please list all of your medications, including dosage/strength and frequency in the chart on the next page.

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Please list all of your current medications

Medication	Dosage/ Strength	Frequency

Provider notes: