Fox Valley Wellness Center/Midwest Hyperbarics

NAME_____ DATE_____

LIFESTYLE HISTORY

DIET

(list specific foods)

1. Breakfast _____ Time _____
2. A.M. Snack _____ Time _____
3. Lunch _____ Time _____
4. P.M. Snack _____ Time _____
5. Dinner _____ Time _____
6. Late Snack _____ Time _____
7. Other _____ Time _____

Do you or have you eaten diet foods or drank diet soda on a regular basis?_____
What is your largest meal? _____
How many B.M.'s per day? _____
Have you ever had a Colonoscopy? _____ If yes, when?_____

SLEEP

1. What time do you go to bed? _____
2. How long to fall asleep? _____
3. Do you wake up during the night? _____ How many times? _____
4. Do you dream? _____
5. What time do you wake up? _____ Do you feel refreshed? _____

FEMALES ONLY

1. Menarche age (age of your first period) _____
2. Menopause age _____
3. Days between periods _____ Days of flow _____
4. Symptoms associated (cramping, PMS, etc.) _____
   Severity (0-10) _____
5. How many pregnancies? _____ Live births? _____
6. Have you ever taken birth control pills? _____When & how long? _____
7. When was you last Pap Smear? _____ Last Mammogram?_____

EXERCISE

1. What type of exercise do you do?_____
2. How many times per week on average _____
3. What length of time per episode?_____
4. Have you ever had a bone density (DEXA) test?_____ If yes when? _____

What type of vaccinations have you had (childhood included) _____
_____
_____