LIFESTYLE HISTORY

NAME ______________________________ **DATE** ______________________

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? Y N

What is your largest meal? ______________________________

How many B.M.'s per day? ________

Have you ever had a Colonoscopy? Y N 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? Y N If yes, how many times? ________
4. Do you dream? Y N
5. What time do you wake up? __________ Do you feel refreshed? Y N

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? Y N If yes, 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? Y N If yes when? ______________

VACCINATIONS (Please list all vaccinations you have had in your lifetime and when):

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